

Health and Emergency Information

Participant Last Name: _____ First Name: _____

Emergency Contact Information (include parent or guardian):

Contact #1:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Contact #2:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

In case of emergency, I (We) hereby authorize designated representatives of the Citizenship Washington Focus program to consent on my behalf to medical treatment and/or hospital care as advised and deemed necessary by emergency medical staff, physicians or surgeons. I (We) also understand that all financial obligations incurred, if not covered by insurance, will be my responsibility.

Additionally, I (We) have also read and noted that in case of emergency while attending Citizenship Washington Focus, participants may be contacted as follows:

Delegate's Name
CWF Week 7
National 4-H Youth Conference Center
7100 Connecticut Avenue
Chevy Chase, MD 20815
Phone: (301) 961-2801.

I (We) agree that this participant can safely attend Citizenship Washington Focus.

Participant's Signature: _____ **Date:** _____

Parent/Guardian's Signature: _____ **Date:** _____

Participant Name: _____

Date of last flu shot: _____ **Date of last tetanus booster:** _____

Please indicate “yes” or “no” for each of the following. If “yes” enter details indicating diagnosis, date of illness, name of hospital, length of hospitalization, name of doctor, and any other pertinent information.

	Yes	No
Nervous or Psychological Problems such as epilepsy, emotional stress, convulsions, loss of consciousness, dizziness, paralysis, frequent anxiety, excessive crying.	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease Asthma, blood spitting, persistent cough, tuberculosis, abnormal chest x-rays.	<input type="checkbox"/>	<input type="checkbox"/>
Disease of Heart or Blood Vessels, increased or abnormal blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Stomach or Intestinal Trouble Ulcers, gall bladder or liver disorder, jaundice, hernia, colitis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Diabetes, Kidney or Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever or Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to Medicines (including penicillin, tetanus)	<input type="checkbox"/>	<input type="checkbox"/>
Impaired site or hearing, chronic ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Recent surgical operations, accidents or injuries	<input type="checkbox"/>	<input type="checkbox"/>
Been a patient in a hospital (other than a recent surgical operation)	<input type="checkbox"/>	<input type="checkbox"/>
Any infectious disease or contact within the past two months	<input type="checkbox"/>	<input type="checkbox"/>
Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to Foods (please be sure to notify 4-H staff of special dietary needs)	<input type="checkbox"/>	<input type="checkbox"/>
Under on-going care of a physician for chronic or recurring problem	<input type="checkbox"/>	<input type="checkbox"/>
Currently taking medicines (list names and doses)		

Please list any special assistance needed, such as dietary or accessibility restrictions:

You will jeopardize your position in your preferred week if you do not send all forms on time.
Must be postmarked by April 1, 2011 to
WI 4-H Outreach, 436 Lowell Hall, 610 Langdon St., Madison WI 53703