

# YOUTH HEALTH INFORMATION & CONSENT FOR EMERGENCY TREATMENT

## “Accept the Challenge”

National 4-H Congress, Atlanta, Georgia

November 23-27, 2007

Parent/Guardian: Complete & have notarized BETWEEN November 1-7.

Attach  
labeled  
photo  
here

This information is confidential and necessary for proper care by staff advisors and medical personnel.

Please type or print legibly in BLACK ink.

Do not leave empty blanks; enter N/A if not applicable. Incomplete forms will be returned!

### Participant Information:

Last Name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  Female  Male

**Health:** Has this delegate experienced any of the following illnesses/injuries/diseases/disorders/problems or symptoms? If you check “yes” to any of the following, **enter the details below** including diagnosis, treatment, date of illness or injury, name of hospital, name of physician and telephone number. Continue on reverse side of page, if necessary.

- | YES                      | NO                       | CONDITION  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to bee stings. Explain _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to dyes (red dye, food coloring). Explain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to environmental factors (pollen, mold, dust, hay fever). Explain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to foods: Explain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to latex. Explain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to medicines including penicillin, tetanus, etc. Explain _____<br>How does this person react to the(se) allergy(ies)? _____<br>Normal treatment? _____     |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder or bowel control, bedwetting. Explain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes or hypoglycemia (low blood sugar). Explain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating disorders (anorexia, bulimia or other). Explain _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional or mental (severe homesickness, reaction to stress, frequent anxiety, excessive fears, etc.).<br>Explain concern and suggested method of handling it _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Exposure to a contagious or serious disease recently. Explain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye or ear (color blindness, peripheral vision, depth perception, near or farsightedness, ear infection, impaired hearing or other). Explain _____                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart (high/low blood pressure, murmurs, chest pain, rheumatic fever, etc.).<br>Explain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney or gall bladder Explain _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Learning or attention disorders. Explain _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Limiting physical conditions (sitting, standing, walking). Is special equipment or assistance needed?<br>Explain _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular/skeletal (arthritis, recent fractures, etc.). Explain _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervous system (convulsions, epilepsy, dizziness, etc.). Explain _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Nose or throat (thyroid, lymph nodes, carotid arteries, other). Explain: _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Reproductive (menstrual difficulties, other). Explain: _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory (asthma, persistent/chronic cough, abnormal chest x-ray, tuberculosis, or any other lung problems). Explain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin (rash, other). Explain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep (sleepwalking, recurrent nightmares, other). Explain: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach, liver or intestinal (ulcers, jaundice, hernia, colitis, indigestion, etc.).<br>Explain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgical operations, accidents or injuries in the past 2 years. Explain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Vascular and blood (anemia; Hepatitis B or C; hemophilia, HIV positive; HBV; migraines, nosebleeds, transfusions, unconsciousness/fainting, other). Explain _____    |

(over)

**Continued explanations of "yes" answers:**

**Other important health information** that the Adult Advisors should know? \_\_\_\_\_

**Contagious diseases:** list dates of exposure and occurrence of the following: Measles, Mumps, Rubella, Chicken Pox, Mononucleosis, Tuberculosis, Pneumonia \_\_\_\_\_

**Dietary needs/restrictions:**

List special dietary needs or restrictions: \_\_\_\_\_

**General attitude/mood/alertness** (shyness, energy level, cooperation) \_\_\_\_\_

**Immunizations -- list dates of last vaccines:**

Hepatitis \_\_\_\_\_ Influenza \_\_\_\_\_ Tetanus \_\_\_\_\_ MMR (Measles/Mumps/Rubella) \_\_\_\_\_

Was this a second MMR immunization? \_\_\_\_\_

**Medications:**

List all prescriptions/non-prescription medications participant will require during the program, listing dosages, time medications are taken, and sensitivity to them: \_\_\_\_\_

Do you want an adult advisor to collect and dispense medications?  yes  no

**Social habits** (smoking or chewing tobacco, alcohol consumption, illicit drug use) Explain: \_\_\_\_\_

**Insurance information:**

Insurance Co. \_\_\_\_\_ Policy Number \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**Physician information:**

Family Physician or Clinic \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Date of last medical examination: \_\_\_\_\_ Is participant under a doctor's care now?  yes  no

**Parent/Guardian information:**

Last Name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Day phone (\_\_\_\_\_) \_\_\_\_\_ Evening phone (\_\_\_\_\_) \_\_\_\_\_

**Alternate contact in case of emergency:**

Name \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Day phone (\_\_\_\_\_) \_\_\_\_\_ Evening phone (\_\_\_\_\_) \_\_\_\_\_

*I understand that failure to provide complete information on this health form could hinder chaperones' and staff's ability to provide adequate care and could result in termination of my son/daughter's participation in this event.*

*I am of the opinion that \_\_\_\_\_ can **safely participate** in this program. I consider his/her health to be:  Excellent  Good  Fair  Poor. I further declare that he/she has no physical, mental, or communicable conditions that will interfere with participation in this program.*

*I will notify the State 4-H Office of any changes in health or prescriptions between now and departure. I understand my son/daughter will be supervised and that if a serious illness or injury develops, medical and/or hospital care will be given but Wisconsin 4-H and program staff are not responsible in case of accidental injury or illness. I or the person noted above will be notified as soon as possible in case of medical emergency while my son/daughter is participating in this program. If a medical emergency arises, I give permission for emergency treatment or surgery as recommended by an attending physician. I agree to cover cost of prescriptions and emergency transportation to medical facilities or home, if necessary.*

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

*(Must be signed in the Presence of a Notary Public Regardless of Age of Delegate)*

\_\_\_\_\_  
*Notary Public*

State of \_\_\_\_\_ County of \_\_\_\_\_

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_

My commission expires \_\_\_\_\_, 20\_\_\_\_\_.

**Must be completed, notarized & postmarked between November 1-7.**

**Send to**

**WI Outreach, 431 Lowell Hall, 610 Langdon St., Madison WI 53703**