

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: Currently covered by insurance: ___ Yes ___ No

Insurance Co. _____ Policy Number _____

Insurance Co. Address _____

Telephone: _____

Physician information:

Family Physician or Clinic _____ Phone _(_____)_____

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

Emergency Contact:

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 staff's ability to provide adequate care and could result in termination of my participation in this event.

*I am of the opinion that I can **safely participate** in this program. I consider my health to be: Excellent Good Fair Poor. I further declare that I have 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 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. The person noted above will be notified as soon as possible in case of medical emergency while I am 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 _____ Date _____

(Must be signed in the presence of a Notary Public)

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, 2008.

Send to

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