

**“Accept the Challenge”**  
**2009 National 4-H Congress**  
**November 27 – December 1, 2009**  
**Atlanta, Georgia**

**Attach an  
 Identification  
 Photograph  
 Labeled on the Back**

**CONFIDENTIAL**

**ADULT HEALTH FORM**

**CONFIDENTIAL**

Name of Delegate: \_\_\_\_\_  
LAST FIRST MIDDLE

Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_  
Month Day Year Male Female

Home Address: \_\_\_\_\_  
Number and Street/PO Box

\_\_\_\_\_ City/State/Zip Code

Emergency Contact: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Alternate Emergency Contact: \_\_\_\_\_  
Name

Alternate Emergency Phone: \_\_\_\_\_  
Phone Number

**To be completed and signed before a Notary Public:**

I am of the opinion that I can **SAFELY PARTICIPATE** in National 4-H Congress and that I have no contagious or communicable diseases. My health is **POOR FAIR GOOD** *(strike out words that do not apply)* and I have had no illnesses within 30 days prior to departure. In case of emergency while participating in National 4-H Congress, permission is given for physicians to perform needed treatment. I will assume all financial obligations incurred if not covered by insurance.

Signature \_\_\_\_\_

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

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

Sworn to and subscribed to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

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

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If the answer is "yes" to any of the following, enter the details in the space provided indicating the diagnosis, date of illness, name of hospital, length of hospitalization, name of doctor, etc.

	YES	NO
1 NERVOUS OR MENTAL Problems such as epilepsy, emotional stress, convulsions, loss of consciousness, dizziness, paralysis, Frequent anxiety, excessive crying. <i>If yes, please explain:</i>	<input type="checkbox"/>	<input type="checkbox"/>
2 LUNG DISEASE Asthma, blood spitting, persistent cough, tuberculosis, abnormal chest x-rays. <i>If yes, please explain:</i>	<input type="checkbox"/>	<input type="checkbox"/>
3 DISEASE OR HEART OR BLOOD VESSELS, INCREASED OR ABNORMAL BLOOD PRESSURE <i>If yes, please explain:</i>	<input type="checkbox"/>	<input type="checkbox"/>
4 PAIN IN THE CHEST OR SHORTNESS OF BREATH Heart murmur, rheumatic fever <i>If yes, please explain:</i>	<input type="checkbox"/>	<input type="checkbox"/>
5 STOMACH OR INTESTINAL TROUBLE Ulcers, gall bladder or liver disorders, jaundice, hernia, colitis. <i>If yes, please explain:</i>	<input type="checkbox"/>	<input type="checkbox"/>
6 ARTHRITIS, DIABETES, KIDNEY OR BLADDER DISEASE <i>If yes, please explain:</i>	<input type="checkbox"/>	<input type="checkbox"/>
7 HAY FEVER OR ALLERGIES <i>If yes, please explain:</i>	<input type="checkbox"/>	<input type="checkbox"/>
8 ALLERGIES TO MEDICINES (including Penicillin, Tetanus) <i>If yes, please explain:</i>	<input type="checkbox"/>	<input type="checkbox"/>

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9 IMPAIRED SIGHT OR HEARING, CHRONIC EAR INFECTIONS *If yes, please explain:*

10 RECENT SURGICAL OPERATIONS, ACCIDENTS OR INJURIES *If yes, please explain:*

11 BEEN A PATIENT IN A HOSPITAL (other than #10) *If yes, please explain:*

12 ANY INFECTIOUS DISEASE OR CONTACT WITH INFECTIOUS DISEASE IN THE TWO WEEKS PRIOR TO THIS TRIP. *If yes, please explain:*

13 SKIN DISEASE *If yes, please explain:*

14 ALLERGY TO FOODS *If yes, please explain:*

15 MEDICATIONS YOU ARE CURRENTLY TAKING (list name and doses) *If yes, please explain:*

16 UNDER ON-GOING CARE OF A PHYSICIAN FOR CHRONIC OR RECURRING PROBLEM (Name and number of physician) *If yes, please explain:*

17 DATE OF LAST FLU SHOT: \_\_\_\_\_

18 DATE OF LAST TETANUS BOOSTER: \_\_\_\_\_

19 LIST ANY SPECIAL NEEDS OR CONCERNS (*Attach additional page if need more space*)

**PLEASE CARRY A COPY OF THIS FORM WITH YOU DURING YOUR TRIP.**

**Must be completed, notarized & postmarked between November 1-6, 2009.**

**Send to**

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