

DODGE COUNTY 4-H HEALTH FORM

DATE _____ EVENT _____
 NAME _____ SEX ___ M ___ F BIRTHDATE _____
 PARENT/GUARDIAN NAME _____ HOME PHONE _____
 ADDRESS _____ WORK PHONE _____
 CITY _____ WISCONSIN ZIP _____
 Family Physician _____ Phone No _____
 Family Health Ins. Co _____ Phone No _____ Ins No _____
 This individual was LAST EXAMINED BY A PHYSICIAN: MONTH _____ YEAR _____

IS THIS INDIVIDUAL SUBJECT TO / BOTHERED FREQUENTLY WITH ANY OF THE FOLLOWING:

	Yes	No		Yes	No		Yes	No
Menstrual Cramps	___	___	Drug Sensitivity	___	___	Fainting Spells	___	___
Cold/Flu	___	___	Hernia	___	___	Headaches	___	___
Ear Infection	___	___	Heart Trouble	___	___	Upset Stomach	___	___
Sinusitis	___	___	Rheumatic Fever	___	___	Athlete Foot	___	___
Tonsillitis	___	___	Asthma/Hay Fever	___	___	Epilepsy	___	___
Sore Throat	___	___	Constipation	___	___	OTHER	___	___

ALLERGIES: _____
 Medication or Treatment for Allergies: _____

IS YOUR CHILD CURRENTLY TAKING MEDICATION? Yes ___ No ___

If YES, please explain WHAT MEDICATION: _____

If the First Aid Coordinator feels it is appropriate, could your child be given Tylenol? Yes ___ No ___

WHAT VACCINATIONS/IMMUNIZATIONS has this individual had? (Specify years given, if known)

*Include DATE of last tetanus booster

Has this person been exposed to communicable disease/had an illness within past 2 weeks? Yes ___ No ___

IF YES, WHAT DISEASE/ILLNESS? _____

Has this individual stayed overnight from the family before? Yes ___ No ___

EYEGLASSES: Yes ___ No ___ CONTACT LEANSES Yes ___ No ___ (Please mark with child's name)

Is this child subject TO ANY OF THE FOLLOWING:

Tires easily	___	Yes	___	No	Fear of Darkness	___	Yes	___	No
Bed Wetting	___	Yes	___	No	Homesickness	___	Yes	___	No
Nightmares	___	Yes	___	No	Sleepwalking	___	Yes	___	No
Fear of Water	___	Yes	___	No	Special Diet	___	Yes	___	No

Other: _____

If you responded YES to any of the above, PLEASE COMMENT on the current situation: _____

Activities the child SHOULD NOT participate in _____

This health history is correct as far as I know, and my son/daughter/ward has my permission to engage in all prescribed activities, except as noted by me and the physician. In the event of serious injury or illness, I WILL BE NOTIFIED. If I CANNOT BE REACHED IN AN EMERGENCY, I hereby give my permission to the physician to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my son/daughter/ward. I also agree not to hold Dodge County and UW-Extension responsible for any personal injury or accident while on a 4-H sponsored county activity.

I understand as a parent/guardian signing this form that I will be held financially responsible for any expenses above and beyond what the 4-H insurance will pay.

Parent/Guardian Signature _____ Date _____

IF PARENTS ARE NOT AVAILABLE IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____ Relationship to Child _____ Phone _____