Program Health Form

Name of Program: _____

Name_____ Date_____

Sex_____M_____F Age_____ Birth date_____

Parent/Guardian Name_____ Home Phone_____

Address_____ Work Phone_____

City_____ State_____ Zip Code_____

Family Physician_____ Phone Number_____

Family Health Insurance Company_____ Insurance #_____

Describe any current injury/sickness/medication, etc._____
_____
_____

What vaccinations/immunizations has this individual had? Specify year given, in known.
_____
_____

Has person been exposed to any communicable diseases within the past two weeks?
____Yes ____No

Has this person been advised by your family physician at this time to:

Limit physical exercise ____Yes ____No
Take special medications _____Yes _____No
Special diet _____Yes _____No
_____Other; Please Specify _____

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 the _____ County 4-H Adult/Junior Leaders Associations liable for any personal injury or accident while at this 4-H activity.

_____ _____
Signature of Parent/Guardian Date

***** If parents are not available in case of emergency, please notify:**

Name_____ Phone_____