

County: _____

Pennsylvania 4-H and Youth Development

MEDICAL INFORMATION

Name: _____ Date of Birth: _____
Last First Middle

Home Address: _____ Home Phone: (_____) _____
SS#: _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Home Phone: (_____) _____
Last First Middle

Address: _____ Office Phone: (_____) _____
Other: (_____) _____

Name: _____ Home Phone: (_____) _____
Last First Middle

Address: _____ Office Phone: (_____) _____
Other: (_____) _____

HEALTH INFORMATION: (Please state the facts in connection with the following)

Describe any condition requiring medication as a treatment: _____

List any medications which have been prescribed by the family doctor for the 4-H'er to take on her/his own while attending the program:

List any allergies: _____

Any surgery in the past year? _____ If yes, please state nature: _____

Name of Family Physician: _____ Phone: (_____) _____

Indicate health history information below. A check means yes. Please explain any checks in the space provided.

- | | |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Respiratory problems-Asthma, Tuberculosis, persistent cough, etc. | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Heart problems-high or low blood pressure, Rheumatic Fever, etc. | <input type="checkbox"/> Emotional or mental disorders |
| <input type="checkbox"/> Stomach or intestinal problems-ulcers, jaundice, hernia, colitis, indigestion, etc. | <input type="checkbox"/> Recent exposure to a contagious disease |
| <input type="checkbox"/> Eye, Ear, Nose, Throat-Hay fever, ear infections, impaired sight or hearing | <input type="checkbox"/> Currently under a doctor's care |
| <input type="checkbox"/> Nervous disorder-convulsions, epilepsy, dizziness, etc. | <input type="checkbox"/> Physical limitations |
| | <input type="checkbox"/> Kidney, gall bladder or liver disease |
| | <input type="checkbox"/> Diabetes or hypoglycemia |
| | <input type="checkbox"/> Muscular/Skeletal-arthritis, recent fractures |
- Approximate date of last physical: _____

Please explain any checks: _____

IMMUNIZATION INFORMATION:

Diphtheria: _____ Pertussis: _____ Poliomyelitis: _____ Typhoid: _____

Other(s): Date of last Tetanus injection: _____

RECOMMENDATIONS AND RESTRICTIONS

Any treatment to be continued _____

Any medication to be administered (specific dosages) All medications must be brought to event in their original containers. _____

Any medically prescribed meal plan or dietary restrictions _____

Is there any other information that staff need to know about your child? _____

List any special accommodations that are needed in order to participate in the program: _____

PARENTAL AUTHORIZATION FOR EMERGENCY MEDICAL CARE

MUST BE SIGNED BY PARENT/GUARDIAN

If medical information changes I agree to notify the Extension Office. I hereby authorize you, in the event of an emergency, that is, when you are unable to reach me for authorization or when circumstances require immediate action, to proceed according to good medical practice with treatment of my daughter/son. Also, I authorize the hospital attending physician, or other health care specialist administering the treatment to release pertinent information to the insurance company assuming coverage for the same.

Parent's/Guardian's Signature

Date

Insurance Company Name: _____ Policy Number: _____

Insurance Company Address _____

Insurance Company Phone Number: _____ Subscriber Name: _____

Penn State encourages persons with disabilities to participate in its programs and activities. If you anticipate needing any type of accommodation or have questions about the physical access provided, please contact _____ in advance of your participation or visit.

Note: Some hospitals may require that this form be notarized in order for them to accept the parent's or guardian's signature. Please check with the hospital in your area or where your event will be held.

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