MISSISSIPPI STATE UNIVERSITY EXTENSION

Extension Center for 4-H Youth Development

Health & Medical Emergency Form

Program Year: 20___ to 20___ **Date completed: _____(month, day, year)**

CONFIDENTIAL

4-H member's full name _____

Date of birth _____ Sex ☐ Male ☐ Female

Insurance company _____ Policy number _____

Parent/guardian name _____ Phone _____

Alternate emergency contact _____

Alternate emergency phone _____ Relationship to participant _____

Please check yes or no for each question below.

☐ Yes ☐ No Respiratory issues or lung disease? *Examples: asthma, persistent cough, abnormal chest X-rays, tuberculosis*

☐ Yes ☐ No Heart/cardiovascular disease? *Examples: heart murmur, abnormal blood pressure*

☐ Yes ☐ No Diabetes, arthritis, kidney/bladder disease?

☐ Yes ☐ No Stomach/intestinal problems? *Examples: ulcers, gall bladder or liver problems, jaundice, hernia, colitis*

☐ Yes ☐ No Skin disease?

☐ Yes ☐ No Infectious disease in the past month? *Or any contact with someone with an infectious disease*

☐ Yes ☐ No Impaired sight/hearing?

☐ Yes ☐ No Allergies/hay fever?

☐ Yes ☐ No Allergies to medications? *Examples: penicillin, sulfates, tetanus*

☐ Yes ☐ No Allergies to foods?

☐ Yes ☐ No Chronic illness/recurring problems?

☐ Yes ☐ No Surgeries, accidents, or injuries in the past 6 months?

☐ Yes ☐ No Currently taking medication?

Continued on reverse.

If you answered yes to any of the questions above, enter the details in the space below, indicating the diagnosis, date of illness, and any other important information. Attach additional pages as needed.

Date of last flu shot: _____

Date of last MMR vaccine: _____

Date of last tetanus vaccine: _____

Date of last chicken pox vaccine: _____

List any special needs or concerns:

Please list any over-the-counter medications Extension personnel may administer as necessary:

Read the following statement, then sign and date below.

I affirm that the individual named above can safely participate in a Mississippi 4-H event/activity and that they have no contagious or communicable diseases. They have had no major illnesses within 30 days before departure. In case of emergency while participating, permission is given for appropriate medical personnel and/or licensed physicians to provide medical treatment. If necessary, given apparent medical condition, permission is given to transport participant by ambulance, aid car, or program vehicle to a medical facility for evaluation and treatment. Further, I assume all financial obligations incurred if not covered by insurance.

I have carefully read this document, understand its contents, and am fully informed about the activities/events scheduled that may involve certain risks associated with physical activity or potential harm, including recreational games/activities and travel by motor vehicle to off-site educational and leisure activities.

_____ _____

Participant signature Date

_____ _____

Parent/guardian signature Date

Participants under age 18 must have a parent/guardian's signature.

Form 696 (POD-06-25)

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