



# 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.***

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**Form 696** (POD-06-25)

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