

# NC 4-H Youth Development Health History & Authorization Form



**4-H Group / County:** \_\_\_\_\_ **Year:** \_\_\_\_\_ (Must be updated each year)

4-H'ers Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age as of Jan. 1 \_\_\_\_ Gender:  Female  Male Email: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Custodial Parent/Guardian Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Second Parent/Guardian or Emergency Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

If not available in an emergency, notify (Name): \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Health History**

The following information should be filled in by the parent/guardian, or adult. Update required annually. For residential camp attendance, health exam must be completed by an approved licensed medical personnel within 24 months of participation in the camp. The intent of this information is to provide NC 4-H health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to NC 4-H. Provide complete information so that the NC 4-H can be aware of your needs.

**MEDICATIONS**

Please list ALL medications, even over-the-counter or nonprescription drugs, including Tylenol, Pepto-Bismol, Benadryl, etc. that may be taken. If attending out of county events, bring enough medication to last the entire time you are away. Keep it in the original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis

This person takes medications as follows:

Med#1 _____	Reason _____	Dosage _____	Time taken _____
Med#2 _____	Reason _____	Dosage _____	Time taken _____
Med#3 _____	Reason _____	Dosage _____	Time taken _____
Med#4 _____	Reason _____	Dosage _____	Time taken _____

This person may take the following medications as needed:

Aspirin     Tylenol     Ibuprofen     Benadryl     Pepto-Bismol     Other \_\_\_\_\_

Known allergies to foods, drugs, insect stings or bites, etc: \_\_\_\_\_

**Restrictions - The following restrictions apply to this individual:**

**Dietary**

Vegetarian

Vegan

Other (describe) \_\_\_\_\_

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary): \_\_\_\_\_

**General Questions** (Explain "yes" answers.)

	Yes	No		Yes	No
Has/does the participant:					
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	13. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	14. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had joint problems?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	20. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have problems sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever been dizzy/passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	22. Have a history of bed wetting?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever had seizures	<input type="checkbox"/>	<input type="checkbox"/>	23. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			



## Authorization Form

**Custody Release:** You may be asked to produce photo ID at check-out. This is for your child's safety. Please be aware of this policy before picking up your child. I hereby give permission for my child, \_\_\_\_\_, to be allowed to leave the 4-H program after the activity. My child will be released into the custody of:

\_\_\_\_\_  
(Names of Individuals authorized to pick up your child)

If it is necessary for my child to leave before the end of the program due to illness, injury, or behavioral issues, and I cannot be reached, I hereby give permission for my child to be released into the custody of:

\_\_\_\_\_  
(Emergency contact or other individual authorized to pick up your child)

**For 4-H Use Only:** 4-H'er picked up by: \_\_\_\_\_ Staff Signature \_\_\_\_\_

**Parent/Guardian Authorization:** This health history is correct and complete as far as I know. The person herein described has permission to engage in all 4-H activities except as noted.

I hereby give permission to the NC 4-H to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to NC 4-H to arrange necessary related transportation for me/my child.

The person herein described has permission to engage in all 4-H activities except as noted here: \_\_\_\_\_

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by NC 4-H to secure and administer treatment including hospitalization, for the person named above. This completed form may be photocopied for trips out of county.

Signature of parent/guardian, or adult camper/staffer: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_