



HEALTH RECORD FORM
FLORIDA 4-H PROGRAMS



Name of Activity _____

Participant's County _____ Activity Dates: _____

- 1. Please type or print.
2. Carry this form with you to the activity.
3. Statement provides basis for medical care while at this 4-H activity. You will not be denied admission for medical reasons unless you have a condition which may be harmful to other members of the group or for which appropriate facilities and/or medical treatment are not available.

PERSONAL INFORMATION

Form with fields: Last Name, First Name, Middle Name, Birthdate, Height, Weight, Permanent Address, Age, Sex, Race, City, State, Zip, Social Security Number (4-H Member), Social Security Number (Attending Adult).

NEXT OF KIN OR PERSON TO BE NOTIFIED IN CASE OF EMERGENCY

Form with fields: Name, Address, Relationship, Phone, City, State, Zip, Physician's Name, Phone(s).

STATEMENT OF UNDERSTANDING AND AUTHORIZATION FOR TREATMENT

In consideration of _____ having been accepted by the Cooperative Extension Service to attend a 4-H activity, I hereby release the Florida Cooperative Extension Service, its employees and the volunteer 4-H leader(s) from any financial responsibilities for the sickness of or accident to her/him. I also give my permission for him/her to be treated in case of medical emergency, while going to, returning from and while at this activity. To insure prompt attention in case of serious sickness or accident, I hereby authorize the person responsible to incur expenses considered necessary and I agree to pay for same, if this is not covered by an accident and sickness insurance policy.

I also give my consent for my son or daughter to be under the disciplinary control of the official chaperon(s) designated by Florida Cooperative Extension Service.

Parent/Guardian Signature

Sworn to and subscribed before me this ___ day of _____, 19__.

Participant Signature

Notary Public: _____ Personally Known ___ OR Produced Identification ___

Date

Type of Identification Produced _____

THIS FORM MUST BE NOTARIZED (over)

MEDICAL PROCEDURES SUGGESTED:

COMPLETED

YEAR

RUBELLA VACCINATION

DIPHTHERIA TETANUS IMMUNIZATION (WITHIN 10 YEARS)

POLIO SERIES

MEASLES VACCINE

_____	_____
_____	_____
_____	_____
_____	_____

IF THE ANSWER IS "YES" TO ANY OF THE FOLLOWING, ENTER DETAILS ON THE LINES PROVIDED, INDICATING DIAGNOSIS, DATE OF ILLNESS OR INJURY, NAME OF HOSPITAL, LENGTH OF HOSPITALIZATION, NAME OF DOCTOR, ETC.

MY CHILD HAS HAD:

**Answer
Yes or No**

1. SYMPTOMS SUCH AS EPILEPSY, CONVULSION, LOSS OF CONSCIOUSNESS, DIZZINESS, PARALYSIS _____
2. DISEASE OF HEART OR BLOOD VESSELS, INCREASED OR ABNORMAL BLOOD PRESSURE _____
3. LUNG DISEASE: ASTHMA, BLOOD SPITTING, PERSISTENT COUGH _____
4. PAIN IN CHEST OR SHORTNESS OF BREATH _____
5. STOMACH OR INTESTINAL TROUBLE: ULCERS, GALL BLADDER OR LIVER DISORDER, JAUNDICE, HERNIA _____
6. ARTHRITIS, RHEUMATIC FEVER, GOITER, DIABETES, KIDNEY OR BLADDER DISEASE _____
7. HAY FEVER OR ALLERGY _____
8. IMPAIRED SIGHT OR HEARING, CHRONIC EAR INFECTIONS _____
9. ANY SURGICAL OPERATIONS, ACCIDENT OR INJURIES _____
10. SKIN DISEASES _____
11. ALLERGY TO MEDICINES _____
12. CURRENTLY TAKING MEDICINES _____
13. UNDER CARE OF PHYSICIAN _____
14. THERE ARE CERTAIN TYPES OF ACTIVITIES MY CHILD SHOULD NOT PARTICIPATE IN _____

ENTER DETAILS FOR "YES" ANSWERS:

(IF ADDITIONAL SPACE IS NEEDED, STAPLE OR OTHERWISE FIRMLY ATTACH EXTRA PAGES.)

BLOOD TYPE (IF KNOWN) _____

THIS FORM MUST BE FILLED OUT BY THE PARENT OR LEGAL GUARDIAN OF PERSONS UNDER AGE 18. IT SHOULD BE CARRIED WITH THE PARTICIPANT TO THE 4-H ACTIVITY.