

4-H Club/Program  
**PARTICIPANT HEALTHFORM**

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Mail this form to:  
(4-H Club/Program Group Leader address)

Make copies to provide to County Event Chairs

Attendance dates: from: \_\_\_\_\_ to \_\_\_\_\_

Participant Name: \_\_\_\_\_  
First Middle Last

Male  Female Birth Date \_\_\_\_\_ Age on arrival at program \_\_\_\_\_  
Month/Day/Year

■ **To Parent(s)/Guardian(s):** Please follow the instructions below. Attach additional information if needed.

- 1. **Complete pages 1, 2 and 3 of this form (and make a copy for yourself).**  
■ 2. **Send the original, signed form to program by requested date.**

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

**Parent/guardian with residential placement and/or decision-making authority in the event of illness or injury:**

Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(If different from above) Street Address City State Zip Code

**Second parent/guardian with legal custody to be contacted in case of illness or injury:**

Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**Additional parent/guardian to be contacted in case of illness or injury:**

Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**Allergies:**  No known allergies.  This participant is allergic to:  Food  Medicine  The environment (insect stings, hay fever, etc.)  Other  
*(Please describe below what the participant is allergic to and the reaction seen, in detail. Please describe preventative or responsive measures.)*  
 This participant has a life-threatening allergy. An emergency care plan signed by physician is required.

**Diet, Nutrition:**  This participant eats a regular diet.  This participant eats a vegetarian diet (describe details below).  
 This participant has special food needs. *(Please describe below.)*

**Immunizations:**

- My child is up-to-date on his/her immunizations and tetanus shots as required by Washington State law.  
 My child has an immunization exemption on file with his/her school. I understand and accept the risks to my child from not being fully immunized.

**Medication:**

We will be unable to administer medication to children. If your child requires a dosage during activity/event hours, please make appropriate arrangements. Medication<sup>1</sup> is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **All medications must be in their original containers. Prescriptions must have the child's name and how the medication should be given printed on the prescription container. Please send only those medications that are necessary.**

**Medications Currently being taken: (must list)**

- This participant will not take any daily medications while attending the activities.  
 This participant will be **self-administering** the following daily medication(s) while attending the activities.<sup>1</sup>

Participant Name: \_\_\_\_\_

First

Middle

Last

(For Camp Use) Cabin or Group \_\_\_\_\_

(For Program Use) Session Code(s) \_\_\_\_\_

<sup>1</sup> Note: These provisions regarding administration of medication shall not abrogate minors' rights to provide their own consent to certain services under Washington law.

4-H Club/Program  
**PARTICIPANT HEALTH FORM**

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Participant Name: \_\_\_\_\_  
First Middle Last

Birth Date: \_\_\_\_\_  
Month/Day/Year

**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Has/does this participant:

- |  |                              |                             |   |                              |                             |
|--|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| 1. Ever been hospitalized?.....                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise?.....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Ever had surgery?.....                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses?.....          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 14. Ever had back/joint problems?.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Had a recent infectious disease?.....           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 15. Have problems with diarrhea/constipation?.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Had a recent injury?.....                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 16. Have any skin problems?.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Has asthma/wheezing/shortness of breath?.....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 17. Traveled outside the country in the past 9 months?.....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have diabetes?.....                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 18. Had Sickle Cell disease or traits?.....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Had seizures?.....                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 19. Had high blood pressure? .....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Had headaches?.....                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 20. Had cardiovascular disease or other heart problems? .....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 21. Have a history of heart disease (not limited to conjunctive heart defect, cardiomyopathy, abrythemia?)..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Had fainting or dizziness?.....                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |   |                              |                             |

**Please explain "Yes" answers in the space below,** noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

**Restrictions:**

- I have reviewed the program and activities of the program and feel the participant can participate without restrictions.  
 I have reviewed the program and activities of the program and feel the participant can participate with the following restrictions or adaptations. **(Please describe below.)**

**Does the participant require reasonable accommodation for a disability in order to access or be part of the activities?**

**What Have We Forgotten to Ask? Please provide in the space below** any additional information about the participant's health that you think important or that may affect his or her ability to fully participate in the program. **Attach additional information if needed.**

**This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all program activities except as set forth by me and/or an examining physician. If you fail to advise WSU of a medical condition, WSU is not responsible for related injuries. I understand the information on this form will be shared on a "need to know" basis with WSU staff and volunteers. I give permission to photocopy this form. In addition, the health care provider has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.**

Signature of Custodial \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardians: Keep a copy for your records.**