NEW ENGLAND 4-H MEMBER HEALTH FORMS

Member/Volunteer Information

Last Name	First	Middle Initial	M F Sex	/ / Date of Birth
Street Address	City	State	Zip Code	( ) Home Phone No.

Notify In Case of Emergency (Emergency Contacts will be notified in order listed until one contact is reached)

Name Relationship	Name Relationship
Address	Address
City State Zip Code	City State Zip Code
( ) ( ) ( ) Home Telephone Work Telephone Cell Telephone	( ) ( ) ( ) Home Telephone Work Telephone Cell Telephone

Allergies

Food (List Food)	Life Threatening?	Yes	No
Drug (List Drug)	Life Threatening?	Yes	No
Insect (List Insect)	Life Threatening?	Yes	No
Other (List)	Life Threatening?	Yes	No

Personal Medical History

Previous Surgery/Hospitalization? Explain.

Date

Physical Limitations? Explain

Date

Mental Health Issues Requiring Treatment? Explain

Date

Current Medications? List

Date

Parent/Guardian Authorizations

I recognize that some activities have an inherent risk that could result in personal injury. The person herein described has permission to engage in all 4-H activities except as noted: Please list here:

I hereby give permission to the medical personnel to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected to secure and adminster treatment, including hospitalization, for the person named above. I (we) understand that all financial obligations incurred, if not covered by insurance, will be my responsiblity. This form may be photocopied for specific events. This health form will be maintained in a confidential manner.

All fairgoers & exhibitors may be photographed or filmed by our staff photographers or videographers while on our grounds. Film and Footage taken on our grounds are the property of Eastern States Exposition for possible use in its promotional materials. Entrance to our grounds precludes any and all financial compensation.

Signature of Parent or Guardian Date

Printed Name Date

For religious reasons, my child may not be treated by a medical doctor

Signature of Parent or Guardian Date