

## **Maine 4-H Health Form**

Name: Last	First	MI	Preferred	<u> </u>
Home Address:				
Birth Date	Gender			
Custodial parent(s	or guardian(s) (if under 18	):		
Name	Phone: Home	Cell	Work	
Name	Phone: Home	Cell	Work	
Home address (if d	ifferent from above)			
If you are not avail	able in an emergency whom	should we notif	y?	
Name	Relationship			
Phone: Home	Cell		Work	
Address				
care personnel with the information needed to should be shared with the participant cannot to be a direct threat to Allergies  1. Is this person aller	Head ded here by the parent, guardian, the background needed to provide a provide a safe, healthy, and appropriate 4-H staff. This information will reperform program requirements the health or safety of others.  The gic to any food, medication, or other all allergens and describe your children.	appropriate care, copriate 4-H expernot be used to excludith or without a her substance? Ye	and the program personnel with ience. Any changes to this informude a participant from participat reasonable accommodation, or is	the lation ion unless
2. Has this person ev  If yes, please expla	er had any unusual reaction to an	insect bite or bee	sting? Yes No	
homeopathic reme	urrently take a prescribed medicated in the control of the control	se complete the M	ledications section of this form.	 [
<ol><li>Does this person s</li><li>Yes No</li></ol>	elf-administer any medication, su	icn as an inhaler, o	r carry and Epipen or Anakit?	

container that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. **Attach additional pages if needed.** Medication #1 \_\_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken \_\_\_\_\_ Reason for taking \_\_\_\_\_ Medication #2 \_\_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken \_\_\_\_\_ Reason for taking \_\_\_\_ Dietary Restrictions - Please check all that apply □ Does not eat pork
 □ Does not eat eggs
 □ Does not eat dairy produc
 □ Other (please describe) ☐ Does not eat red meat ☐ Does not eat dairy products ☐ Does not eat poultry ☐ Does not eat gluten **Disabilities or Physical Restrictions:** Please describe any disabilities or physical restrictions for this person of which you want us to be aware, and any reasonable adaptations or accommodations requested: Any person who needs accommodations for the program should contact the appropriate UMaine 4-H staff to discuss their needs, preferably at least 21 days in advance. Please use this space to provide any additional Information about this person's behavior and physical, emotional, or mental health (such as bedwetting, toilet issues, and sleepwalking) that UMaine 4-H staff members should be aware of to provide a safe, healthy, and appropriate experience. **Parent or Guardian Authorization:** This health history is correct and complete as far as I know. The person herein described has permission to engage in all program activities except as noted in this Health History. I hereby give permission to UMaine 4-H to provide routine health care, administer prescribed or other medications, and seek emergency medical treatment including ordering x-rays or routine tests. I give permission to UMaine staff to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission for the physician selected by UMaine staff to secure and administer treatment, including hospitalization, for my child. This completed form may be photocopied for trips. Parent, Guardian or Adult Participant Signature \_\_\_\_\_ I also understand and agree to abide by any restriction placed on my participation in program activities by medical personnel. Minor or Adult Participant Signature\* \_\_\_\_\_\_ Date \_\_\_\_\_ \*if you cannot sign this for religious reasons, contact UMaine 4-H for a legal waiver that must be signed to allow attendance.

Please list ALL medications (including over-the-counter medications and homeopathic remedies) taken routinely.

Bring enough medication to last the entire program. ALL items should be in their original packaging, bottle, or

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