Maine 4-H Health Form

Name: Last __________ First __________ MI ______ Preferred __________

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 different from above) ___________________________________

If you are not available in an emergency whom should we notify?

Name ___________________ Relationship _________________________________

Phone: Home _______________ Cell __________________ Work _______________

Address _____________________________________________________________

Insurance Information

Is this person covered by family medical and hospital insurance? Yes _____ No _____

If so, provide carrier and plan name __________________ Group # __________

Health History

The information provided here by the parent, guardian, or adult participant is intended to provide UMaine 4-H health care personnel with the background needed to provide appropriate care, and the program personnel with the information needed to provide a safe, healthy, and appropriate 4-H experience. Any changes to this information should be shared with 4-H staff. This information will not be used to exclude a participant from participation unless the participant cannot perform program requirements with or without a reasonable accommodation, or is determined to be a direct threat to the health or safety of others.

Allergies

1. Is this person allergic to any food, medication, or other substance? Yes _____ No _____

   If yes, please list all allergens and describe your child's reaction to them:

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

2. Has this person ever had any unusual reaction to an insect bite or bee sting? Yes _____ No _____

   If yes, please explain:

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Medications

1. Does this person currently take a prescribed medication or treatment (Including over-the-counter and homeopathic remedies)? Yes _____ No _____ if yes, please complete the Medications section of this form.

2. Does this person self-administer any medication, such as an inhaler, or carry an Epipen or Anakit? Yes _____ No _____

continued on back of form
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 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 red meat ☐ Does not eat pork ☐ Does not eat eggs
☐ Does not eat poultry ☐ Does not eat seafood ☐ Does not eat dairy products
☐ Does not eat gluten ☐ Other (please describe) _______________________

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 ______________________________________ Date __________________________
Printed Name _____________________________ Date __________________________
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.