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 and 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 _____

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.