

# NEW ENGLAND 4-H MEMBER HEALTH FORMS

## Member/Volunteer Information

Last Name	First	Middle Initial	M	F	/	/
					Sex	Date of Birth
StreetAddress	City	State	ZipCode		( )	
					HomePhoneNo.	

## 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	
( )	( )	( )	
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 administer treatment, including hospitalization, for the person named above. I (we) understand that all financial obligations incurred, if not covered by insurance, will be my responsibility. 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
<b>For religious reasons, my child may not be treated by a medical doctor</b>	
Signature of Parent or Guardian	Date