



## 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**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Does not eat red meat | <input type="checkbox"/> Does not eat pork             | <input type="checkbox"/> Does not eat eggs           |
| <input type="checkbox"/> Does not eat poultry  | <input type="checkbox"/> Does not eat seafood          | <input type="checkbox"/> Does not eat dairy products |
| <input type="checkbox"/> Does not eat gluten   | <input type="checkbox"/> 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:

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**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.

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**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.