Mississippi 4-H Health & Medical Emergency Form

Please type or print clearly.

CONFIDENTIAL

Participant's name: _____
First Middle Last

Date of birth: _____ Gender: ☐ Male ☐ Female
Month Day Year

Insurance company: _____ Insurance policy number:_____

Parent/guardian name:_____ Home phone: _____

Work phone: _____ Cell phone: _____

Alternate emergency
contact name: _____ Relationship to participant: _____

Alternate emergency
home phone: _____

Alternate emergency
cell phone: _____

If the answer is "yes" to any of the following, enter the details in the space provided, indicating the diagnosis, date of illness, name of hospital, length of hospitalization, name of doctor, etc.

1. Respiratory issues or lung disease? ☐ Yes ☐ No
   Asthma, persistent cough, abnormal chest x-rays, tuberculosis, blood spitting. If yes, please explain:

2. Heart or cardiovascular disease? ☐ Yes ☐ No
   Heart murmur, abnormal blood pressure. If yes, please explain:

3. Diabetes, arthritis, kidney, or bladder disease? ☐ Yes ☐ No
   If yes, please explain:

4. Stomach or intestinal problems? ☐ Yes ☐ No
   Ulcers, gall bladder or liver, jaundice, hernia, colitis. If yes, please explain:

5. Skin disease? ☐ Yes ☐ No
   If yes, please explain:

6. Any infectious disease or contact with infectious disease in the past month? ☐ Yes ☐ No
   If yes, please explain:

7. Impaired sight or hearing? ☐ Yes ☐ No
   If yes, please explain:

8. Allergies or hay fever? ☐ Yes ☐ No
If yes, please explain:

9. Allergy to medicines? ☐ Yes ☐ No
Penicillin, sulfates, tetanus. If yes, please explain:

10. Allergy to foods? ☐ Yes ☐ No
If yes, please explain:

11. Under ongoing care of a physician for a chronic or recurring problem? ☐ Yes ☐ No
(Give name and number of physician.) If yes, please explain:

12. Recent surgical operations, accidents, or injuries in the past six months? ☐ Yes ☐ No
If yes, please explain:

13. Are you currently taking medications? ☐ Yes ☐ No
If yes, list name and dosage:

14. Date of last flu shot: _____ 15. Date of last MMR vaccination:_____

16. Date of last tetanus vaccination: _____ 17. Date of last chicken pox vaccination: _____

18. List any special needs or concerns: _____
_____
_____
_____
_____

I affirm that the individual named above can safely participate in a Mississippi 4-H event/activity and that he or she has no contagious or communicable diseases. He or she has had no major illnesses within 30 days prior to departure. In case of emergency while participating, permission is given for appropriate medical personnel and/or licensed physicians to provide medical treatment. If necessary, given apparent medical condition, permission is given to transport participant by ambulance, aid car, or program vehicle to a medical facility for evaluation and treatment. Further, I assume all financial obligations incurred if not covered by insurance.

I have carefully read this document, understand its contents, and am fully informed about the activities/events scheduled that may involve certain risks associated with physical activity or potential harm, including recreational games/activities and travel by motor vehicle to off-site educational and leisure activities.

Participant signature _____ Date _____

Parent/guardian signature _____ Date _____
Youth (under age 18) must have signature of parent/guardian.

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Distributed in Mississippi by the MSU Extension 4-H Youth Development Program.

MISSISSIPPI STATE UNIVERSITY EXTENSION

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