

Texas 4-H Youth Development Program
HEALTH AND SAFETY STATEMENT

Check one: Youth Adult County: _____
Event: _____ Event Dates: _____

Section I. Participant Information

First Name: _____ Date of Birth: _____ Age _____ Gender: _____
Last Name: _____ Name of Physician: _____
Address: _____ Physician's Number: _____
City, State, Zip: _____ Date of last physical exam: _____
Phone: _____

Section II. Emergency Contact Information

Name: _____ Home Phone: _____
Address: _____ Work Phone: _____
City, State, Zip: _____ Cell Phone: _____

Section III. Health History (Check the appropriate answer and explain any YES responses.)

Have you had or do you currently have any heart problems (dates): _____ Yes ___ No ___
Do you frequently suffer from pains in your chest: _____ Yes ___ No ___
(NOTE: If you have any heart related problems you will need to have a physician's release.)
Do you often feel faint or have spells of severe dizziness: _____ Yes ___ No ___
Has a doctor ever told you that you might have high blood pressure: _____ Yes ___ No ___
Are you a smoker: _____ Yes ___ No ___
Do you have arthritis, joint, or back problems that can be aggravated by exercise: _____ Yes ___ No ___
Have you had any operations or serious injuries (dates): _____ Yes ___ No ___
Do you have any chronic recurring illness or communicable diseases: _____ Yes ___ No ___
Are there any activities to be limited/discouraged by a physician's advice: _____ Yes ___ No ___
Are you allergic to any medications, food or food ingredients, insects, or pollens: _____ Yes ___ No ___
Do you have Epilepsy: _____ Yes ___ No ___
Do you have Diabetes: _____ Yes ___ No ___
Do you have any prescribed meal plan or dietary restrictions (explain) _____ Yes ___ No ___
Any other health related information for 4-H personnel to be aware of: _____ Yes ___ No ___

Section IV: Medications (ALL medications must be in ORIGINAL container with ORIGINAL LABEL.)

Are there prescribed or over-the-counter medications currently being taken _____ Yes ___ No ___

Section V. Insurance Information – Please provide a copy of your insurance card.

Do you carry family medical/hospital insurance? _____ Yes ___ No ___
Carrier: _____ Policy _____

Section VI. Release of Participant (If minor)

I/We do hereby authorize the release of said minor child to the following person/people at the conclusion:
(please list all persons, including parents)

Further, I/We require that said minor child NOT be released to the following person/people at the conclusion of the activity:

Section VII. Health and Safety Statement Certification

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand this information is confidential and is to be used only by AgriLife Extension Staff or designated Volunteers for health and safety reasons. I hereby consent to the use of this information for such purposes.

Signature of Participant: _____ Date: _____
Or guardian if participant is under the age of 18)