



Emergency & Medical / Health Information

Name _____ Birth date _____ Sex _____ Age _____
 Parent or guardian _____ Email _____
 Mailing address _____
 Physical address _____
 Home phone _____ Work phone _____ Cell phone _____

Relatives or friends to act in my behalf, in case of emergency, if I cannot be reached:

<i>Emergency contact name/relationship</i>	<i>Emergency contact name/relationship</i>
<i>Home phone</i>	<i>Home phone</i>
<i>Alternate phone</i>	<i>Alternate phone</i>
<i>Address</i>	<i>Address</i>

Family physician _____ Phone _____

Under doctor's care now? _____ If yes, please explain on back.

Prescribed medicine _____

(All meds must be turned in to chaperone or camp nurse.)

Note: If bringing medications to the event or program, please make sure that your name is on them and that dosage directions are clearly indicated.

Allergies to medications/foods/insects/other? _____ List _____

Health History: Is youth subject to: Indicate **YES** or **NO**

_____ Hernia	_____ Hay fever	_____ Nervous disorders	_____ Asthma
_____ Frequent colds	_____ Fainting spells	_____ Sleepwalking	_____ Ear/sinus
_____ Allergies	_____ Insect stings	_____ Drug sensitivity	_____ Enuresis (bed wetting)
_____ Epilepsy	_____ Heart trouble	_____ Diabetes (take insulin?)	
_____ Food allergies	_____ Bleeding/clotting disorders		

If **YES** on any of the above, please explain _____

Has the youth had:

_____ Poliomyelitis	_____ Hay fever	_____ Rheumatic fever
_____ Appendicitis attack	_____ Measles	_____ Mumps
_____ Chicken pox	_____ Whooping cough	_____ Scarlet fever

Is the youth pregnant? _____ Date of last tetanus booster: _____

Identify any physical/emotional problems that would prevent full participation in the program. _____

Emergency Authorization: I hereby give my permission to the medical staff selected by the Cooperative Extension Service faculty/staff to order x-rays, routine tests and treatment for the above named youth. In the event I, or one of the above named designees cannot be reached in an emergency, I hereby give my consent to emergency medical treatment, hospitalization or other medical treatment as needed. I will assume all financial obligations incurred if not covered by insurance.

Signature of parent/guardian _____
Date

Leaders should keep a copy of this form to have available when they are with club members.