HEALTH STATEMENT **Southeast District 9 4-H**

_____Health screening performed
_____Follow-up referred to: _____Dietary _____Camp Director _____Dorm Staff

Check one: _____ Youth _____ Adult County _____ Camp Leadership Lab

The proposed activity provided by Southeast District 9 4-H, requires participation in physical exercises, which are, by their nature, physically demanding. Many of the activities will challenge you, and cause surges in blood pressure and pulse rates. It is imperative that you are free of any heart related or other disease. Therefore, all participants must be free of medical or physical conditions which might create undue risks to themselves or any others who depend on them. If there is any doubt about your ability to safely participate in this experience, you should have a physical examination.

Section I. Participant Information

Name_____ Date of Birth_____ Age_____ Gender_____
Address_____ Name of Physician_____
City, State, Zip_____ Physician's Phone_____
Home Phone_____ Date of last physical exam_____

Section II. In the event of an Emergency, please contact:

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 (please describe)_____ YES_◯_ NO_◯_
Are all immunizations up-to-date:_____ YES_◯_ NO_◯_
Date of last Tetanus shot_____
Any other health related information for Center personnel to be aware of: _____

PLEASE NOTE: **ALL** medications must be in **ORIGINAL container with ORIGINAL LABEL**.

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

Are there prescribed medications currently being taken (please describe)_____ YES_◯_ NO_◯_

Please check "over the counter" medications which camp personnel may administer as necessary:

____ Immodium ____Pepto Bismol ____Ibuprofen (Motrin) ____ Acetaminophen (Tylenol)
____ Neosporin ____Benadryl ____Robitussin DM or CF ____ Any as needed

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

Signature_____ Date_____