Virginia Cooperative Extension

Virginia Tech • Virginia State University

Adult 4-H Health History Report Form

Publication 4H-224 (4H-893NP)

INSTRUCTIONS: Please provide information concerning your health for participation in 4-H Events for the current year. If you are a person with a disability and desire any assistive devices, services, or other accommodations to participate in activity, please contact your local Extension office during business hours at least 7 days prior to the event to discuss accommodations. **PLEASE PRINT ALL INFORMATION**. (NOTE: Both sides of this form must be completed.)

COUNTY _____

IDENTIFICATION

NAME _____ GENDER_____

Last *First* *MI*

MAILING ADDRESS _____ CELL PHONE (_____) _____

CITY _____STATE_____ ZIP_____HOME PHONE (_____)_____

BIRTHDATE _____ EMAIL_____

EMERGENCY CONTACT

NAME _____ CELL PHONE (_____) _____

ADDRESS _____ HOME PHONE (_____) _____

RELATIONSHIP_____ WORK PHONE (_____) _____

PHYSICIAN/INSURANCE INFORMATION

NAME OF PHYSICIAN _____ PHONE (_____) _____

MEDICAL/HOSPITAL INSURANCE _____

Carrier *Policy ID #*

MEDIA RELEASE

The Virginia Polytechnic Institute and State University/College of Agriculture and Life Sciences (CALS) periodically uses electronic and traditional media (e.g., photographs, video, audio footage, testimonials) for publicity and educational purposes. By my signature on this form, I acknowledge receipt of this document and give permission to the College of Agriculture and Life Sciences and its designee to use such reproductions for educational and publicity purposes in perpetuity without further consideration from me.

I understand that I will need to notify Virginia Tech/College of Agriculture and Life Sciences if any changes to my situation occur that will impact this media release permission.

PLEASE INITIAL YES_____ NO_____

*18 USC 707

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IMMUNIZATION HISTORY (This must be completed)

Date of most recent tetanus shot: (month/year) _____

HEALTH AND MEDICAL HISTORY
(*Optional*)

Special Dietary Needs

_____

_____

Do you have a history of any of the following? Check all that apply.

☐ Allergies	☐ Fainting spells	☐ Wears Dentures
☐ Asthma	☐ Seizures/Convulsions	☐ Surgery
☐ Bleeding disorders	☐ Heart condition	☐ Serious illness/injury
☐ Diabetes	☐ Wears Contacts	Other_____

Please describe any condition or need that you checked: _____

_____

_____

_____

Are you experiencing any current health problems, under medical care, receiving mental or behavioral services, or currently taking medication? If YES, please explain: _____

_____

_____

_____

Other information you feel important to share: _____

_____

_____

APPROVAL/EMERGENCY AUTHORIZATION

I hereby give permission in the event of accident or injury for the medical staff or representative to secure proper treatment for, hospitalize, and to order injection and/or anesthesia and/or surgery for me. I understand that all attempts will be made to notify my emergency contacts of any such serious illness or injury.

I hereby understand the nature and scope of the activities I am participating and agree to participate subject to limitations noted herein. This form may be photocopied for use outside of the event/activity location.

ADULT PRINTED NAME _____

SIGNATURE_____ **DATE**_____

(Note: If for any reason you cannot sign this, you must contact your Extension office to obtain a legal waiver that must be signed.)