UNIVERSITY OF MARYLAND EXTENSION

MARYLAND 4-H EVENT HEALTH FORM

Current Photo Of Participant

Participant's Name: _____
Last *First* *MI* *Nickname*

Sex:
☐ Male
☐ Female

Gender Identity:
☐ Male ☐ Nonbinary
☐ Female ☐ Other
☐ Prefer not to State

Age: _____
Birthdate: _____ *MM/DD/YYYY*

☐ Youth Participant
☐ Adult Participant

Home Address: _____ *Street Address*
_____ *City* *State* *ZIP* *County*

4-H Event Attending: _____

Event Dates: _____ *MM/DD/YYYY* to _____ *MM/DD/YYYY*

Event Location: _____

PARENT/GUARDIAN or Other Person to be Notified in case of Injury or Illness:

Name:_____ Relationship: _____ Preferred Phones: #1 _____ #2 _____
Indicate mobile (M), home (H), work (W)

Email: _____

Home Address: *if different from participant* _____
Street Address *City* *State* *ZIP*

SECOND PARENT/GUARDIAN or Other Emergency Contact:

Name:_____ Relationship: _____ Preferred Phones: #1 _____ #2 _____
Indicate mobile (M), home (H), work (W)

Email: _____

ADDITIONAL CONTACT in event parent/guardian or others cannot be reached:

Name:_____ Relationship: _____ Preferred Phones: #1 _____ #2 _____
Indicate mobile (M), home (H), work (W)

Email: _____

HEALTH CARE PROVIDER CONTACTS: **Name:** **Phone:**

Primary Care Physician: _____ _____

Dentist: _____ _____

Other (specify): _____ _____ _____

HEALTH INSURANCE: Is participant covered by health/medical insurance? ☐ Yes ☐ No

Insurance Company: _____ Phone Number: _____

Policyholder's Name: _____ Policy Number: _____

Attach photocopy of insurance card; be sure to copy both sides of card so information is readable

AUTHORIZATION FOR PARTICIPTION AND RELEASE: I certify that this health history is correct and accurately reflects the health status of the individual to whom it pertains. I hereby give permission for medical personnel selected by University of Maryland Extension (UME) to provide routine health care; to order x-rays, and routine tests; to administer medications, injections, anesthesia, surgery, and other treatment; to release records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission for medical personnel selected by UME to secure and administer treatment including hospitalization for the participant named above. I further understand that I will be responsible for medical/hospital bills. By signing this form, I give permission for the participant named above to participate in all program activities except as specified herein. This completed form may be copied for official use. This authorization shall remain in effect for the duration of the event specified above, to include the duration of any travel to/from the event. By signing this form, I release and forever discharge, agree not to sue, and to indemnify and hold harmless the State of Maryland, University of Maryland, and University of Maryland Extension and/or their officers, agents, employees, faculty, staff, and volunteers from and against any and all liabilities, costs, expenses, causes of action, claims, and/or demands in any way relating to the foregoing program activities and/or the health, illness, injury, and/or treatment of the participant named above.

Signature of Youth's Parent/Guardian: _____ **Date:** _____ **Relationship to Participant:** _____

Signature of Adult Participant: _____ **Date:** _____

UNIVERSITY OF MARYLAND EXTENSION

PARTICIPANT HEALTH HISTORY

Participant's Name: _____

☐ Youth ☐ Adult

If the answer is "yes" to any of the questions listed below, explain below the question. Attach additional pages or documents as necessary.		
Have you been seriously ill or had contact with anyone with an infectious disease in the last 30 days? *(If yes, explain)*	☐ Yes	☐ No
Have you traveled outside the country in the last year? *(If yes, list countries and dates of travel)*	☐ Yes	☐ No
Have you recently been injured, had an accident, suffered a concussion (brain injury) or had surgery? *(If yes, explain)*	☐ Yes	☐ No
Do you have any **allergies to medicines**? *(If yes, list and explain reaction)*	☐ Yes	☐ No
Do you have any **food or environmental allergies**? *(If yes, list and explain reaction)*	☐ Yes	☐ No
Do you carry an **emergency medical device or medication** (epi-pen, inhaler, etc)? *(If yes, explain and state where on your body you carry the device/medication)*	☐ Yes	☐ No
Do you have impaired **sight, hearing**, or chronic ear infections? *(If yes, explain)*	☐ Yes	☐ No
Do you have any **nervous, neurological or mental health**-related issues, such as epilepsy, seizures, dizziness, loss of consciousness, migraines, emotional stress, anxiety, or attention/behavioral disorders? *(If yes, explain)*	☐ Yes	☐ No
Do you have **heart or respiratory** issues such as asthma, breathing disorders, persistent cough, heart murmur, chest pain, abnormal blood pressure, blood diseases, etc? *(If yes, explain)*	☐ Yes	☐ No
Do you have **stomach or intestinal** disorders such as ulcers, gall bladder, IBS, colitis, hernia, etc? *(If yes, explain)*	☐ Yes	☐ No
Do you have **autoimmune** disorders such as diabetes, arthritis, lupus, kidney or bladder disease, etc? *(If yes, explain)*	☐ Yes	☐ No
Do you have **skin** diseases or disorders? *(If yes, explain)*	☐ Yes	☐ No
Do you take **prescription medications** for any chronic or long-term condition? *(If yes, list the medications and explain)*	☐ Yes	☐ No
Do you have any **dietary restrictions or limitations**? *(If yes, explain)*	☐ Yes	☐ No
Do you have any medical conditions or special needs or circumstances not addressed above? *(If yes, explain)*	☐ Yes	☐ No
Date of most recent **Tetanus immunization:**	_____ *(MM/DD/YYYY)*	