WASKOWITZ WSU 4-H CHALLENGE HEALTH FORM Youth Program

Group Name: _____ Program Date:_____

_____ _____ Male ___ Female ____
Name of youth Birthdate

_____
Address City State Zip

MEDICAL HISTORY

YES NO

☐ ☐ 1. Do you have any physical complaints or chronic illness at this time?
If yes, what: _____

☐ ☐ 2. Have you had injuries in the past (i.e., back, knee, shoulder, elbow, etc.)?
If yes, what: _____

☐ ☐ 3. Are you currently under the care of a physician or practitioner of any sort?
If yes, why: _____

☐ ☐ 4. Are you taking medicines of any type?
If yes, what: _____

☐ ☐ 5. Are you on a special diet?
If yes, what kind: _____

6. Do you have or have you ever had:
☐ ☐ a. Diabetes? If yes, are you taking insulin? How much? _____
☐ ☐ b. Seizures?
☐ ☐ c. Asthma? **If you have an inhaler please bring that with you on the course**
☐ ☐ d. Allergies? To what: _____
☐ ☐ * e. Are you allergic to bee stings? Type of reaction: _____
_____
*If yes, **(please carry your medication with you on the course)**
☐ ☐ f. Any other medical information? _____

7. **Emergency Contact Person**: _____
Emergency Contact Phone Number: _____

Name of Physician: _____

Address: _____ Phone: _____

Name of Insurance: _____ Group & ID Number: _____

I approve of emergency care for myself or the above minor under the direction of the event leader or consulting doctor, if I am unable to make my wishes known. (Cross out the last statement if you do not wish to grant medical consent). I have read, understand and agree to the above listed statement and do sign this agreement of my own free will. I hereby release 4-H, its employees and volunteers from any and all liability with relationship to the above mentioned person's participation on the Waskowitz 4-H Challenge / Ropes Course. This release includes the transportation to and from the site of the activities as well as the activities themselves.

_____
Signature of Participant (if 18 or older)
if under 18, signature of parent/guardian