

4-H Participant Information/Enrollment Form (NOT FOR RESIDENTIAL CAMP)

Note: The form must be completed by the participant and/or parent or guardian in order to participate in the 4-H program. **All items must be completed, even if the response is not applicable – indicate by using N/A (i.e. no health insurance).** Failure to complete this form in its entirety will result in the person being ineligible to participate in 4-H activities. Please print in blue or black ink to allow for photocopying.

Name: _____ County/District: _____
Last First

Address: _____ Birth date: _____ Age: _____ Youth Female
 Adult Male

City: _____ State: KY Zip: _____ Email: _____ Home Phone: _____ Farm: Yes No

Race: Asian White Black American Indian Hawaiian & Pacific Islander Hispanic Non-Hispanic Grade: _____

Emergency Contact #1: _____ Phone H W C _____ Phone H W C _____

Emergency Contact #2: _____ Phone H W C _____ Phone H W C _____

Name of Family Doctor: _____ Doctor's Phone: _____

Health Insurance Company: _____ Policy #: _____

Name of Policy Holder/Relationship to Participant: _____ Member ID: _____

HEALTH HISTORY

Does the participant have, or at any time has had, any of the following? Check "Yes" or "No" to each item. Please explain any "yes" answers (noting the number of the item) in the space below or on an additional sheet if necessary. Reporting conditions will not prevent a person from attending and will be kept confidential.

	Yes	No
1) Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
2) Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>
3) Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>
4) Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
5) Ear Infection.....	<input type="checkbox"/>	<input type="checkbox"/>
6) Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>
7) Heart Condition.....	<input type="checkbox"/>	<input type="checkbox"/>
8) Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
9) Hypoglycemia.....	<input type="checkbox"/>	<input type="checkbox"/>
10) Serious Allergy to Insects.....	<input type="checkbox"/>	<input type="checkbox"/>
11) Wear Glasses/Contacts.....	<input type="checkbox"/>	<input type="checkbox"/>
12) Other Conditions.....	<input type="checkbox"/>	<input type="checkbox"/>
13) Drug Allergy (please explain).....	<input type="checkbox"/>	<input type="checkbox"/>
14) Food Allergy (please explain).....	<input type="checkbox"/>	<input type="checkbox"/>
15) Other Allergy (please explain).....	<input type="checkbox"/>	<input type="checkbox"/>

Please Explain Any "Yes" Responses:

List and explain any restrictions (dietary, physical, etc):

The following over the counter medications may be administered to my child without contacting me:

- Antihistamine Pill Antacid Ibuprofen (Advil) Hydrocortisone Cream
 Acetaminophen (Tylenol) Decongestant Dramamine Polysporin (topical antibiotic)

MEDICAL TREATMENT

All information provided on this form is correct and complete to the best of my knowledge. This person has permission to engage in all events and activities. I hereby give permission to the event designee to provide routine health care, administer prescription and over the counter medications as noted and seek emergency medical treatment if warranted. I agree to the release of all records necessary for medical treatment, billing or insurance. In the event I cannot be reached in an emergency, I give permission to the attending physician to secure and administer treatment, including hospitalization. **SIGNATURE OF PARENT/PARTICIPANT:** _____ **DATE:** _____

PUBLICITY RELEASE

I hereby grant the 4-H program, University of Kentucky and their agents, the right to use, reproduce, assign and/or distribute still pictures, video and sound recordings of myself or my minor child without compensation for use in promotion, advertising, educational publications or online content.

SIGNATURE OF PARENT: _____ **NO, I do not permit.**



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