

Louisiana 4-H Overnight Event Permission/Health Form

(To be completed and signed by parent/guardian prior to event. Participant MAY NOT register without health form)

Name of Participant _____ Date of Birth _____

Last middle first

Address _____ Parish _____

Street or PO Box

City _____ Zip Code _____

Social Security # _____ Gender _____

Parent/Guardian _____

Phone: Home _____ Work _____ Cell _____

If neither parent nor guardian can be located, in case of emergency, call: _____

(include name and phone number)

Persons designated to take child from event: _____

Persons not permitted to take child from event: _____

Family Physician _____ Phone: Office _____ Alternate _____

Health Insurance Company Name _____

Policy No. _____ Group No. _____

Health History

List all known drug allergies: _____

Is there past or present history of the following? Check all that apply.

	Yes	No		Yes	No
Appendicitis	___	___	Joint, back, limb pain	___	___
Asthma	___	___	Kidney or urine problems	___	___
Bedwetting	___	___	Menstrual problems	___	___
Bleeding disorder	___	___	Nervous condition/depression	___	___
Convulsions/fainting	___	___	Nose, sinus problems	___	___
Diabetes/hypoglycemia	___	___	Poison ivy, oak, sumac rash	___	___
Eye, ear problems	___	___	Recent surgery/injury	___	___
Frequent ear infections	___	___	Serious illness	___	___
Heart defect/disease	___	___	Serious injury	___	___
Hernia	___	___	Skin, gland problems	___	___
Hypertension	___	___	Sleepwalking	___	___
Hyperactivity/ADD/ADHD	___	___	Stomach/bowel problems	___	___
Insect stings*	___	___	Physical Disability	___	___

*Localized redness/swelling do not constitute insect allergy. Body-wide rash, swelling, and difficulty breathing do constitute insect allergy (anaphylaxis).

Explain any "Yes" marked above and list any other problems, including any exposure to infectious disease in the two weeks prior to event. _____

Immunizations (latest date): Tetanus _____ Hepatitis _____

Youth must have had a physical examination within the preceding 24 months by a licensed physician or a licensed nurse practitioner.

Date of last physical examination: _____

Special Restrictions

Chronic or recurring illness and treatment which may be needed _____

Membership and participation in activities and events are open to all citizens without regard to race, color, national origin, gender, religion, age, veteran status, or disability. *If you have a disability that requires special accommodation for your participation in this event, please contact your parish 4-H agent two (2) weeks prior to your participation in this event.*

Indicate if your child has special requirements for travel/lodging or dietary needs due to disability or medical restrictions. _____

Dietary modifications require physician's written instructions be given to 4-H staff two (2) weeks prior to the event.

Insurance Information:

LSU AgCenter insures all participants while they attend 4-H sponsored events. This insurance is limited to \$3,000 and does not cover crutches. Remaining medical bills are the responsibility of the participant and his/her parent or guardian.

Parent/Guardian Authorization to participate or exclude participation in event activities:

I give permission for my child to participate in all event activities with the following exceptions:

Parent/Guardian Authorization for Medical Care:

I, the undersigned parent/guardian, understand that although the 4-H staff closely supervises the participants, the 4-H staff is not responsible in cases of accidental injury or illness. In the event first aid is necessary, it will be available on site. I hereby give permission to the physician selected by the 4-H staff to order x-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, permission to secure proper treatment for, hospitalize, order injections and/or anesthesia and/or surgery for my child as named above.

Signature of parent/guardian

Date (month/day/year)

I (parent/guardian) hereby give permission for Louisiana 4-H to administer the following over-the-counter medications if the nurse/med tech deems it necessary. Dosages will be administered according to directions on the bottle unless a parent or physician directs otherwise. **Circle any item(s) you do not want administered to your child.**

Scrapes & cuts	antibiotic ointment
Headache	non-aspirin pain reliever
Upset stomach	bismuth subsaliaylate (stomach relief liquid)
Constipation	milk of magnesia
Diarrhea	anti-diarrheal medicine
Menstrual cramps	ibuprophen
Poison ivy/insect bites	calamine lotion/antihistamine liq./hydrocortisone cream
	benzocaine swabs
Sunburn	sunburn spray/lip balm
Sore throat/cough	sore throat spray/lozenges
Sinus/cold	sinus/cold medications
Sore muscles	muscle rub
Ear ache	swimmer's ear drops

Signed _____ **Date** _____

Photo Release (check one)

_____ I give permission to use my child's name/photo in publications, advertisements, 4-H webpage or news articles pertaining to 4-H activities.

_____ I do NOT give permission to use my child's name/photo in publications, advertisements, 4-H webpage or news articles pertaining to 4-H activities.

Signature of parent/guardian

Date (month/day/year)

By my signature I am verifying that all the above information on this Louisiana 4-H Overnight Event Permission/Health Form is true and accurate.

Parent/Guardian

Date

It is the policy of the Louisiana Cooperative Extension Service that no person shall be subjected to discrimination on the grounds of race, color, national origin, gender, religion, age, or disability.