Volunteer's/ Adult's Name:

Volunteer's/Adult's County:

WSU 4-H Health Form for Adult Members/Participants

About This Form

Fill out the following information accurately, but please be concise. The form below is required for youth members. Any information listed here may be shared with Washington State University faculty and staff, and/or certified 4-H Volunteer Leaders at your County Extension Office's discretion. If you do not wish to share information about a health condition, please choose "Prefer not to state" from the required options.

If a youth member is 18 on the date these forms are signed, please have the youth member sign in the Member and Parent/Guardian fields.

If the youth member is in need of a reasonable accommodation to participate in 4-H events and activities, please see the "4-H Reasonable Accommodation Policy" and fill out the application there.

Fields in **BOLD** are required fields. Your health form will be considered incomplete if any required field remains empty.

This form is valid only for the 2018-2019 4-H Year (October 1, 2018 - September 30, 2019).

Health Information

Allergy Information:

Does this participant have any allergies or reactions (food, drug, plant, insect, etc.)?

- ○ No
- ○ Yes
- ○ Prefer not to state

Describe any allergies and/or reactions, notating if any allergies require medical intervention:

Dietary Needs:

Does this participant have any dietary needs?

- ○ No
- ○ Yes
- ○ Prefer not to state

List any dietary needs here:

General Health Information:

Does this participant have any general health conditions that may affect his/her ability to participate in events?

- ○ No
- ○ Yes
- ○ Prefer not to state

Please list any health conditions that may affect the member's ability to participate in events, including any activities that may be restricted/prohibited due to these conditions:

Additional Information:

Please provide any additional information that may be important for WSU faculty and staff, and/or certified 4-H Volunteer Leaders to know:

Health Care Provider Information

Primary Care Doctor: ____

Primary Care Doctor Phone Number: ____

Secondary Doctor: ____

Secondary Doctor Phone: ____

Insurance Information

I am covered by family medical and/or hospital insurance:

- ○ No
- ○ Yes

Primary Insurance Company:____

Insurance Policy Number: ____

Insurance Subscriber: ____

Emergency Contact

Emergency Contact Name: ____

Emergency Contact Phone Number: ____

Emergency Contact Relationship to Member: ______________________________________

Emergency Medical Release

In an emergency requiring medical attention or a situation reasonably believed to be an emergency by Washington State University (WSU) authorized agents including enrolled 4-H volunteers or event staff, I authorize WSU and its authorized agents to obtain emergency medical care for me. I will be responsible for any expenses incurred in so doing including, but not limited to, care by health care professionals, hospital care, and ambulance or other services. In addition, the health care provider has permission to obtain a copy of my health record from providers who treat me and these providers may talk with the program's staff about my health status.

I hold harmless and agree to indemnify Washington State University, its authorized agents, and employees from decisions to seek emergency treatment.

Member/Participant Signature: ____

Date: ____

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