4-H

Health Form

Member Info

Member ID

Member Name

Date of Birth

Gender

Primary County

Emergency Contact Name

Emergency Contact Phone

Emergency Contact Relationship

Emergency Contact 2 Name

Emergency Contact 2 Phone

Emergency Contact 2 Relationship

Guardian Name

Guardian Phone

Guardian 2 Name

Guardian 2 Phone

Guardian 2 Work Phone

Allergies

WSU Extension programs are available to all without discrimination. The purpose of conducting this health screening is to ensure the health and safety of all 4-H participants during their 4-H experiences. This information will be used strictly for that purpose. It is important that all information is accurate, concise, and clear. Please answer the "Yes/No" questions truthfully.

Do you have any allergies that are life threatening?

Do you have any additional, non-life threatening allergies?

Do you have any dietary needs that are not considered an allergy?

Care

Please provide the contact information for your Primary Care Doctor or Preferred Health Provider.

Primary Care Doctor or Preferred Health Provider

Primary Care Doctor or Preferred Health Provider Phone

Secondary Doctor or Preferred Health Provider

Secondary Doctor or Preferred Health Provider Phone

Conditions

Are there any health conditions that may affect your ability to participate in 4-H programming as an Enrolled 4-H Youth Member or Certified 4-H Volunteer?

Health Insurance

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

Primary Insurance Company

Insurance Policy Number

Insurance Subscriber

Remarks

Is there any additional health information that may be important for WSU faculty and staff, and/or Certified 4-H Vol

Adult 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 Certified 4-H Volunteers or event staff, I authorize WSU and its authorized agents to obtain emergency medical care for me and/or my minor child. 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/or my minor child and

Member Name

Recorded Member Name

Manager Name

Parent or Guardian Name

Date of Consent