WASHINGTON STATE UNIVERSITY EXTENSION
4-H Youth Development Program

MEMBER'S HEALTH FORM

Do you have any physical complaints or illness at this time?
____ Yes ____ No
If yes, please explain: ________________________
____

Are you under the care of a physician or practitioner of any sort?
____ Yes ____ No
If yes, please explain: ________________________
____

Are you taking any type of medication?
____ Yes ____ No
If yes, what type:
____

In what dosage:
____

Are you on a special diet?
____ Yes ____ No
If yes, please explain: ________________________
____

Do you have Diabetes?
____ Yes ____ No
If yes, type of dosage and insulin:
____

Do you have Asthma?
____ Yes ____ No
If yes, do you carry an inhaler?
____

Do you have any allergies?
____ Yes ____ No
If yes, please list allergies: ____________________
____

Last tetanus shot (month and year)?
____

Other conditions or comments: _________________
____
____
____

____
Physician's Name Phone Number

____
Health Insurance Group/Policy Number

In case of emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the physician selected by the delegation leader to hospitalize and secure proper treatment (including surgery) for my child.

I have read, understand, and consent to the foregoing statements.

____ ________________________
Parent/Guardian Signature Date

____ ________________________
Member/Participant Signature Date