CONFIDENTIAL

UNIVERSITY OF ILLINOIS EXTENSION 4-H PROGRAM
ADULT EMERGENCY MEDICAL INFORMATION

EVENT: _____

PARTICIPANT'S NAME: _____

Address: _____
Street City State/Zip Code

Age: _____ Sex: _____ Date of Birth: _____/_____/_____

EMERGENCY CONTACTS:

Name: _____
Relationship

Home Phone: _(_____)_____-_____ Work Phone: _(_____)_____-_____

Cell Phone: _(_____)_____-_____

Address: _____
Street City State/Zip Code

Name: _____
Relationship

Home Phone: _(_____)_____-_____ Work Phone: _(_____)_____-_____

Cell Phone: _(_____)_____-_____

Address: _____
Street City State/Zip Code

HEALTH INFORMATION STATEMENT

Check below any information you feel staff and/or volunteers may need, to maximize the safety and the well being of the exhibitor or staff member. To the right of the condition statement is space for more information relating to the condition checked. Please be specific. In case of emergency, this health information may be the only source of accurate, important information. This information will be kept confidential unless needed in case of illness or injury and can be returned after the program is concluded.

[ ] Nervous or Mental (epilepsy, emotional stress, convulsions) _____
_____

[ ] Lung Disease (asthma, persistent cough, tuberculosis) _____
_____

[ ] Disease of Heart or Blood Vessels, Increased or Abnormal Blood Pressure_____
_____

[ ] Pain in Chest or Shortness of Breath (heart murmur, rheumatic fever) _____
_____

[ ] Stomach or Intestinal Trouble (ulcers, gall bladder or liver disorder, jaundice, hernia, colitis)
_____

[ ] Arthritis, Diabetes, Kidney or Bladder Disease _____
_____

[ ] Hay Fever or Allergies _____
_____

[ ] Allergy to Medicines (including penicillin, tetanus) _____
_____

[ ] Impaired Sight or Hearing, Chronic Ear Infections_____
_____

[ ] Recent Surgical Operation, Accidents or Injuries_____
_____

[ ] Any Infectious Disease_____
_____

[ ] Skin Disease_____
_____

[ ] Allergy to Foods_____
_____

[ ] Currently taking Medicines (list names & doses) _____
_____

[ ] Medication that needs refrigeration _____
_____

[ ] Under on-going care of a Physician (NAME & PHONE #) for chronic or recurring problem
_____

[ ] Do you wear glasses? YES[ ] NO [ ] SOMETIMES[ ]
[ ] Do you wear contact lenses? YES [ ] NO[ ] SOMETIMES [ ]
[ ] Date of last TETANUS BOOSTER_____
[ ] Date of last FLU SHOT _____
[ ] Significant Orthopedic and/or Neuromuscular Impairment (e.g. loss of limb, spinal cord injury)
_____

Primary Care Physician: _____

Practice/Clinic/Hospital Affiliation: _____

City: _____State: _____Phone: _ (____) _____-_____

Health Insurance Provider: _____

Owner's Name: _____ ID/Policy Number: _____

Medical Privacy Statement: *It is the policy of University of Illinois Extension 4-H Youth Development Programs to keep any medical information it may have regarding 4-H Youth Development program participants confidential. However, there may be time in which such medical information will be needed and may need to be shared with others. Examples of sharing might include: providing information to medical personnel in the event of an emergency so that an adult may be treated; providing information to Extension staff or volunteers who are coordinating specific events in the case of a request for reasonable accommodation; and providing information to chaperones or host families who are responsible for the health and safety of program participants at a specific event. Except in the case of emergency, prior to sharing any medical information, it may have with those external to the University, Extension, or 4-H, every effort will be made to get the permission of the program participant or parent or guardian.*

To my knowledge, I have no health problems, unless stated above, and can SAFELY PARTICIPATE in _____ and that I have no contagious or communicable disease. In case of emergency while participating in this event/program, I give permission for physicians to perform needed treatment. I will assume all financial obligations incurred if not covered by insurance.

SIGNED: _____ DATE: _____
Participant

Return to: (Event Coordinator Address) *Revised 1.10*