UNIVERSITY OF MISSOURI Extension
Live. And Learn.

4-H Health Form

Youth Member Information

First Name: _____ Middle Name: _____

Last Name: _____ Suffix: _____ Preferred Name: _____

Mailing Address: _____ Mailing Address 2: _____

City: _____ State: _____ Zip Code:_____

Birth Date (MM/DD/YYYY) _____ Gender: ☐ Male ☐ Female

Primary Phone:_____ Member Cell Phone: _____

Parent / Guardian 1

First Name **Last Name**

Cell Phone **Work Phone**

Parent / Guardian 2

First Name **Last Name**

Cell Phone **Work Phone**

Work Extension **Address**

Emergency Contact

Name **Phone**

Cell Phone

Health Form

1) Is this individuals Tetanus immunization current?

☐ Yes
☐ No
☐ Not Sure

Date of last Tetanus Shot Month/Year. _____(Leave Blank if not current or unknown)

2) Does this individual have any health diagnosis that is important for staff to know in order to maximize participation and ensure safety and well-being?

☐ No, this individual does not have any relevant health diagnosis.
☐ Yes, this individual has a physical disability, a learning disability, behavioral disorder, and/or mental health diagnosis.

Health diagnosis details/explanations and suggested accommodations:

3) Does this individual have any specific dietary needs?

☐ No special food needs or requests for this individual.
☐ Yes, food allergies or restrictions (e.g. peanuts, gluten-free) or food preferences (e.g. vegetarian)

Describe all dietary needs details/explanations:

4) Does this individual have any conditions requiring medication?

☐ No medications are needed by this individual
☐ Yes, and assistance is needed with medications
☐ Yes, and assistance is *not* needed with medications

Medication details and explanation:

5) Does this individual have any allergies or reactions to drugs or things in nature?
☐ No allergies/reactions
☐ Yes, please describe below:

6) The following are over-the counter, non-prescription, medications may be administered to my child, without contacting me (select all that apply):

☐ Antihistamine (such as Benadryl)
☐ Antacid
☐ Ibuprofen (such as Advil)
☐ Acetaminophen (such as Tylenol)
☐ Decongestant
☐ Dramamine
☐ Hydrocortisone
☐ Polysportin (topical antibiotics)
☐ Calamine Lotion:
☐ Sunscreen
☐ Please contact me for permission to administer any over-the-counter medications

7) Does this individual have any other health related conditions our faculty, staff or program volunteers should be aware of?

☐ No other known health related conditions
☐ Yes, please describe below:

Parent/Guardian Signature: _____ Date: _____