4-H SHOOTING SPORTS EMERGENCY MEDICAL FORM

PARTICIPANT'S NAME: _____

Address: _____
Street *City* *State/Zip Code*

Age:_____ Sex: ☐ F ☐ M Birth Date:_____/_____/_____

PARENT/GUARDIAN/OTHER EMERGENCY CONTACT:

Name: _____
Relationship

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

Address: _____
Street *City* *State/Zip Code*

HEALTH INFORMATION STATEMENT

Place a "Y" (yes) or "N" (no) in the space to highlight any information you feel staff and/or volunteers may need to maximize the safety and the well being of the delegate/chaperone. At the end of the list, please give specific information on any items that you placed a "Y" in the space. Please be specific. In case of emergency, this form may be the only immediate source of accurate important

- ☐ 1. Nervous or Mental *(epilepsy, emotional stress, convulsions)*
- ☐ 2. Lung Disease *(asthma, persistent cough, tuberculosis)*
- ☐ 3. Disease of Heart or Blood Vessels, Increased or Abnormal Blood Pressure
- ☐ 4. Pain in Chest or Shortness of Breath *(heart murmur, rheumatic fever)*
- ☐ 5.Stomach or Intestinal Trouble *(ulcers, gall bladder or liver disorder, jaundice, hernia, colitis)*
- ☐ 6. Arthritis, Diabetes, Kidney or Bladder Disease
- ☐ 7. Hay Fever or Allergies
- ☐ 8. Allergy to Medicines *(including penicillin, tetanus)*
- ☐ 9. Impaired Sight or Hearing, Chronic Ear Infections
- ☐ 10. Recent Surgical Operations, Accidents or Injuries
- ☐ 11. Any Infectious Disease
- ☐ 12. Skin Disease
- ☐ 13. Allergy to Foods
- ☐ 14. Significant Orthopedic and/or Neuromuscular Impairment *(e.g. loss of limb, spinal cord injury)*
- ☐ 15. Under on-going care of a Physician *(give name & phone number below)* for chronic or recurring problem
- ☐ 16. Do you wear glasses OR contact lenses? (*circle*)
- ☐ 17. Currently taking medication *(list names & doses below)*
- ☐ 18. Currently taking medication that needs refrigeration
- ☐ 19. Date of last TETANUS BOOSTER

Please provide any detailed information for any items above marked with a "Y". Be specific.

_____

_____

Family Doctor: _____

Clinic/Hospital Affiliation: _____

City:_____ Phone: (____)_____ -_____

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 a youth 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.*

As a parent or guardian, I understand that if a serious illness/injury develops, medical or hospital care will be given. I further understand that in case of serious illness/injury, I will be notified. However, if it is impossible to contact me, I give my permission for emergency treatment, x-ray or surgery, as recommended by an attending physician.

I also understand that any accident insurance in effect for the event, does not cover pre-existing conditions or self-inflicted injuries. *I understand this insurance also may not cover all expenses and I will be responsible for payment of any expenses over and above the coverage provided.*

SIGNED:_____ **DATE:**_____
Parent or Guardian