Illinois 4-H EMERGENCY MEDICAL FORM

4. Pain in Chest or Shortness of Breath (heart murmur, rheumatic fever)	YOUTH / VOLUNTEER NAM	ME:				
Age:				 State/Zip Code		
Name:	Age:	·	M		•	
Home Phone: (PARENT / GUARDIAN / OTF	HER EMERGENCY CON	TACT			
Home Phone: (Name:					
Address: Street City State/Lip Code	Hama Nama (Wl. Dl		•	
HEALTH INFORMATION STATEMENT Place a "✓" in the box to highlight any information you feel staff and/or volunteers may need to maximize the safety and the well being of the delegate/chaperon. At the end of the list, please give specific information on any items that you placed a "✓" in the space. Please be specific. In case of emergency, this form may be the only immediate source of accurate inpart information. □ 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) □ 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, tetamas) □ 9. Impaired Sight or Hearing, Chronic Ear Infections Please provide any detailed information for any items above marked above. Be specific. □ 19. Date of last TETANUS BOOSTER Medical Privacy Statement: It is the policy of University of Illinois Extension 4-H Youth Development Programs to keep any medical information may have regarding Youth Development program participants confidential. However, there may be time in which such medical information may have regarding Youth Development program participants confidential. However, there may be time in which such medical information may have regarding Youth Development program participants confidential. However, there may be time in which such medical information may have regarding Youth Development program participants confidential. However, there may be time in which such medical information may have regarding Youth Development program participants confidential. However, there may be time in which such medical information may have regarding Youth Development program part			work Phone:	()		
HEALTH INFORMATION STATEMENT Place a "\square\text{"} in the box to highlight any information you feel staff and/or volunteers may need to maximize the safety and the well being of the delegate/chaperon. At the end of the list, please give specific information on any items that you placed a "\square\text{"} in the space. Please be specific. In case of emergency, this form may be the only immediate source of accurate important information. 1. Nervous or Mental (epilepsy, emotional stress, convulsions) 1. Nervous or Mental (epilepsy, emotions) 1. Nervous or Mental (epile						
Place a "✓" in the box to highlight any information you feel staff and/or volunteers may need to maximize the safety and the well being of the delegate/chaperon. At the end of the list, please give specific information on any items that you placed a "✓" in the space. Please be specific. In case of emergency, this form may be the only immediate source of accurate important information. □ 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 Please provide any detailed information for any items above marked above. Be specific. Family Doctor: Clinic/Hospital Affiliation: City: □ Phone:	Address: Street		City		State/Zip Code	
Place a "✓" in the box to highlight any information you feel staff and/or volunteers may need to maximize the safety and the well being of the delegate/chaperon. At the end of the list, please give specific information on any items that you placed a "✓" in the space. Please be specific. In case of emergency, this form may be the only immediate source of accurate important information. □ 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 Please provide any detailed information for any items above marked above. Be specific. Family Doctor: Clinic/Hospital Affiliation: City: □ Phone:		HEALTH INFORM	IATION STAT	EMENT		
Clinic/Hospital Affiliation: City: Phone: Phone: Phone: Phone: Phone: Phone:	 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 		 □ 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 			
Medical Privacy Statement: It is the policy of University of Illinois Extension 4-H Youth Development Programs to keep any medical information may have regarding 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 an emergency so that a youth may be treated; providing information to University 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 re-sponsible 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.	Family Doctor:					
Medical Privacy Statement: It is the policy of University of Illinois Extension 4-H Youth Development Programs to keep any medical information may have regarding 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 an emergency so that a youth may be treated; providing information to University 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 re-sponsible 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:	Clinic/Hospital Affiliation:					
may have regarding 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 an emergency so that a youth may be treated; providing information to University 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 re-sponsible 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:	City:	Phone: (
	may have regarding Youth Development be needed and may need to be shared w an emergency so that a youth may be tre case of a request for reasonable accomm and safety of program participants at a s with those external to the University, Ext guardian. As a parent or guardian, I und understand that in case of serious illness treatment, x-ray or surgery, as recomme does not cover pre-existing conditions of	program participants confider with others. Examples of sharing eated; providing information to nodation; and providing inform pecific event. Except in the ca- tension, or 4-H, every effort wi erstand that if a serious illness, /injury, I will be notified. Howe nded by an attending physicial r self-inflicted injuries. I unders	ntial. However, the g might include: po b University staff of lation to chaperor se of emergency, I Il be made to get if /injury develops, r ever, if it is imposs n. I also understan stand this insurance	ere may be time in who in who in which in the control in the control in the control in the permission of the medical or hospital candible to contact me, I and that any accident in the permission of the medical or hospital candible to contact me, I and that any accident in the control in the	hich such medical information will to medical personnel in the event of a coordinating specific events in the ho are re-sponsible for the health nedical information, it may have a program participant or parent or ire will be given. I further give my permission for emergency nsurance in effect for the event,	
	SIGNED:		D <i>A</i>	ATE:		

