Florida 4-H Participation Form

UF UNIVERSITY of FLORIDA IFAS Extension 4-H Youth Development

Note: This form must be completed by the participant and/or parent or guardian in order to participate in the 4-H program.
All items must be completed, even if the response is not applicable – indicate by using N/A (for example: no health insurance).
This form must be present while traveling to, and during each event.
Failure to complete this form in its entirety will result in the person being ineligible to participate in 4-H activities.

Name: _____ Birth Date: ___/___/___ Age: _____ ☐ Youth ☐ Adult ☐ Female ☐ Male
Last First

Home Address: _____ County/District _____/_____
City, ST Zip: _____ Home Phone: (___) _____
Primary Emergency Contact: _____ Work Phone: (___) _____
Email: _____ Cell Phone: (___) _____
Alternate Emergency Contact: _____ Phone: (___) _____
Name of Family Doctor: _____ Phone: (___) _____
Health Insurance Company: _____ Policy #: _____
Name of Insured: _____ Relationship to Participant: _____

HEALTH HISTORY

Does the participant have, or at any time had, any of the following? Check "Yes" or "No" to each item. Please explain any "Yes" answers (noting the # of the item) in the space below or on an additional sheet of paper if necessary. Reporting conditions will not prevent a person from attending and will be kept confidential.

	Yes	No
1) Asthma	☐	☐
2) Bronchitis	☐	☐
3) Convulsions	☐	☐
4) Diabetes	☐	☐
5) Ear Infection	☐	☐
6) Fainting	☐	☐
7) Heart Condition	☐	☐
8) Headaches	☐	☐
9) Hypoglycemia	☐	☐
10) Serious Insect Stings	☐	☐
11) Wear Glasses	☐	☐
12) Wear Contact Lenses	☐	☐
13) Other Conditions	☐	☐
14) Penicillin Allergy	☐	☐
15) Aspirin Allergy	☐	☐
16) Tetanus Allergy	☐	☐
17) Other Drug Allergies	☐	☐
18) Food Allergies	☐	☐
19) Serious Ivy, Oak, or Sumac	☐	☐
20) Other Allergies	☐	☐
21) Other Health Conditions	☐	☐

Please explain "Yes" answers and provide information on recent medical issues (including injuries and surgeries), allergic reactions, special dietary regulations, present medications, any specific activities to be restricted and other comments.

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Date of Last Tetanus Shot: ___/___/___

The following over-the-counter medications may be administered to my child, without contacting me:

☐ Antihistamine ☐ Antacid ☐ Ibuprofen (Advil) ☐ Acetaminophen (Tylenol)
☐ Decongestant ☐ Dramamine ☐ Hydrocortisone ☐ Polysporin (topical antibiotics)
☐ Other _____ ☐ Please contact me for permission to administer ANY over-the- counter medications.

PUBLICITY RELEASE

I authorize UF IFAS Extension and the Florida 4-H Foundation or their assignees to record and photograph my image and/or voice (or that of my child, if under 18) for use in research, educational and promotional programs. I also recognize that these audio, video and image recordings are the property of UF IFAS Extension and/or the Florida 4-H Foundation.

☐ **No, I do not authorize use of my – or my child's – individual image or voice.**