Virginia Cooperative Extension

Virginia Tech • Virginia State University

4-H Adult Health History Report Form

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INSTRUCTIONS: Please provide information concerning your health for participation in 4-H Events for the current year. If you are a person with a disability and desire any assistive devices, services, or other accommodations to participate in activity, please contact your local Extension office during business hours at least 7 days prior to the event to discuss accommodations. PLEASE PRINT ALL INFORMATION. (NOTE: Both sides of this form must be completed.)

COUNTY _____

IDENTIFICATION

NAME _____ FEMALE ☐ MALE ☐
Last First MI

MAILING ADDRESS _____ CELL PHONE (_____) _____

CITY _____ STATE_____ ZIP_____

HOME PHONE (_____) _____ BIRTHDATE _____ EMAIL_____

EMERGENCY CONTACT

NAME _____ CELL PHONE (_____) _____

ADDRESS _____ HOME PHONE (_____) _____

RELATIONSHIP_____ WORK PHONE (_____) _____

PHYSICIAN/INSURANCE INFORMATION

NAME OF PHYSICIAN _____ PHONE (_____) _____

MEDICAL/HOSPITAL INSURANCE _____
Carrier Policy ID #

MEDIA RELEASE

The Virginia Polytechnic Institute and State University/College of Agriculture and Life Sciences (CALS) periodically uses electronic and traditional media (e.g., photographs, video, audio footage, testimonials) for publicity and educational purposes. By my signature on this form, I acknowledge receipt of this document and give permission to the College of Agriculture and Life Sciences and its designee to use such reproductions for educational and publicity purposes in perpetuity without further consideration from me.

I understand that I will need to notify Virginia Tech/College of Agriculture and Life Sciences if any changes to my situation occur that will impact this media release permission.

PLEASE INITIAL YES_____ NO_____

*18 USC 707

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VT/0114/4H-224

IMMUNIZATION HISTORY

Date of most recent tetanus shot: (month/year) _____

HEALTH AND MEDICAL HISTORY

Special Dietary Needs

_____

_____

Do you have a history of any of the following? Check all that apply.

- ☐ Allergies
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Diabetes
- ☐ Fainting spells
- ☐ Seizures/Convulsions
- ☐ Heart condition
- ☐ Wears Contacts
- ☐ Wears Dentures
- ☐ Surgery
- ☐ Serious illness/injury
- Other_____

Please describe any condition or need that you checked: _____

_____

_____

_____

Are you experiencing any current health problems, under medical care, receiving mental or behavioral services, or currently taking medication? If YES, please explain: _____

_____

_____

_____

Other information you feel important to share: _____

_____

_____

APPROVAL/EMERGENCY AUTHORIZATION

I hereby give permission in the event of accident or injury for the medical staff or representative to secure proper treatment for, hospitalize, and to order injection and/or anesthesia and/or surgery for me. I understand that all attempts will be made to notify my emergency contacts of any such serious illness or injury.

I hereby understand the nature and scope of the activities I am participating and agree to participate subject to limitations noted herein. This form may be photocopied for use outside of the event/activity location.

ADULT PRINTED NAME:_____

SIGNATURE_____ DATE_____

(Note: If for any reason you cannot sign this, you must contact your Extension office to obtain a legal waiver that must be signed.)