

TEXAS 4-H CENTER ADULT HEALTH HISTORY FORM

INSTRUCTIONS: Complete the entire form and bring with you to the Texas 4-H Center. This form will be turned in with any medication you bring, both prescription and non-prescription, to the health room upon your arrival.

District _____ County _____ Program Date _____

Name _____ Male _____ Female _____
FIRST LAST

Address _____ Date of Birth _____ Age _____

City _____ State _____ Zip Code _____ Home Phone _____

Spouse _____ Work Phone _____

Physical Limitations or Handicaps _____

SPECIAL or PRESCRIPTION MEDICATIONS are being taken. Yes No

If YES, list the name of the drug(s) and/or medication, along with the name and phone number of the prescribing physician, dosage, consumption rate and interval:

Please check "over the counter" medications which camp personnel may administer as deemed necessary:

Acetaminophen (Tylenol) Motrin (Ibuprofen) Pepto Bismol Imodium
 Neosporin Benadryl Calamine/Caladryl Any As Needed

Special Dietary Needs or Conditions: (i.e. Food Allergies, Diabetes, etc.) If notified in advance, the Center is happy to accommodate any special needs.

Health History: (Please check any of the following that apply)

<input type="checkbox"/> Frequent Ear Infections	Allergies:	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Heart Defect/Disease		<input type="checkbox"/> Ivy Poisoning
<input type="checkbox"/> Convulsions		<input type="checkbox"/> Insect Stings
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Penicillin
<input type="checkbox"/> Bleeding/Clotting Disorders		<input type="checkbox"/> Other

Operations or Serious Injuries (List along with approximate date): _____

Chronic or Recurring Illness: _____

Name of Family Physician: _____ Phone: _____

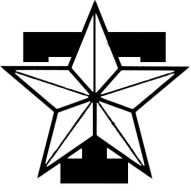
Medical Insurance Carrier: _____ Policy Number: _____

Date of last Tetanus Immunization: _____

*The Health History is correct as far as I know. **Authorization for Treatment:** In the event that I become incapacitated, I hereby give permission to have emergency first aid administered by any qualified person in case of illness and/or injury and to be transported by the most expedient means of conveyance to the nearest available physician, hospital or clinic and to there receive treatment as is medically prescribed by physician(s). In case of extreme illness and/or injury, I do further agree that the Texas Cooperative Extension, the Texas 4-H Youth Development Foundation and their employees or agents, individually or collectively, shall not be held responsible or liable for personal injury or loss resulting on the premises of the Texas 4-H Center.*

Signature _____ Date _____

The Texas 4-H Center considers this privileged information. It will be used for medical reasons only.



WAIVER & RELEASE OF CLAIMS and INDEMNIFICATION AGREEMENT (with Authorization For Medical Care)



This authorization covers _____ during his/her travel to and participation in _____
_____, a 4-H event. This activity covers the period _____ through _____.

I, _____), understand that participation in the activities that make up this event is not without some inherent risk of injury. In consideration of participant's involvement in this event, I hereby release, waive, discharge, and covenant not to sue the sponsor of this event, the State of Texas, The Texas A&M University System, the Board of Regents of the System, Texas A&M University, the Texas Cooperative Extension, the Texas 4-H & Youth Development Program, or any employees or agents of these entities (releasees/indemnities), from any and all liability, claims, or causes of action whatsoever arising out of or related to any loss or injury, including death, that may be sustained by participant, including claims arising from the negligence of releasees. I further agree to defend, hold harmless and indemnify indemnitees from any and all claims and causes of action as a result of participant's involvement and actions at this event, including claims and causes of action arising from the negligence of indemnitees. The foregoing agreements are effective while traveling to and from the event, and while participating in the event and on premises where the activity is being conducted.

I give my permission for participant to be treated for condition requiring emergency medical care, as determined by a health care professional, and accept responsibility for the cost of the treatment. I agree to defend, hold harmless and indemnify indemnitees for any expenses incurred in treating participant. In case of sudden illness or accident to participant, either at the event or traveling to or returning from the event, I authorize Texas Cooperative Extension personnel serving as chaperones to take reasonable action to protect the health and physical well-being of participant. I understand a medical policy carried by American Income Life, if any, may be available to pay certain medical expenses related to treatment of participant. The following information is provided as an aid to the chaperones in dealing with the well-being of participant.

Signature: _____

Date: _____