University of Vermont | Extension College of Agriculture and Life Sciences

Health History and Medical Treatment Form

Youth Participant's Name: _____ DOB: _____ Age: _____

Parent/Legal Guardian Information

Parent/Guardian Name (1): _____ Cell: _____

Email: _____

Parent/Guardian Name (2): _____ Cell: _____

Email: _____

Emergency Contacts In the event, I am not accessible, please contact the following:

Emergency Contact Name (1): _____ Cell: _____

Email: _____

Emergency Contact Name (2): _____ Cell: _____

Email: _____

Health Insurance Information

Insurance Provider: _____ Policy Holder: _____

Policy No. _____ Group No. _____

Primary Care Physician/Practice: _____ Primary Care Physician Phone: _____

Health History

a. Chronic/Ongoing Conditions: _____

_____

Details: triggers, management plan, or accommodations needed for chronic conditions:

_____

_____

b. Allergies (check all that apply):

- ☐ Food (specify) _____
- ☐ Medication (specify) _____
- ☐ Insect Stings
- ☐ Latex
- ☐ Environmental (pollen, animals, etc.) _____

Reactions and treatment required: _____

_____

c. Recent Illnesses, Injuries or Hospitalizations (last 12 months):

_____

_____

d. Diet, Nutrition, or Activity Restrictions (e.g., vegetarian, vegan, gluten-free, lactose-free):

_____

_____

e. Medications (Medication must be brought in the original container issued and labeled by the pharmacy or physician)

Medication: _____ Treatment of: _____

Dosage: _____ Directions: _____

☐ As needed (or) ☐ On a schedule with these administrative specifics:

_____

Medication: _____ Treatment of: _____

Dosage: _____ Directions: _____

☐ As needed (or) ☐ On a schedule with these administrative specifics:

_____

f. Mental, Emotional, Social Health: Are there any underlying mental conditions, medical conditions or health issues not already described above that we should be aware of in order to provide appropriate physical or emotional support for Participant (e.g., sleep walking, bedwetting, homesickness, anxiety, fear of bugs, dogs, dark)?

_____

_____

_____

g. Vaccinations: My child is up-to-date on vaccinations per Vermont State recommendations and guidelines: ☐ Yes ☐ No

Medical Treatment Authorization

I give permission to 4-H staff or a program representative to tend to my child with basic first aid (bug bites, cuts/scrapes, fever/pain reducer, allergy medication, etc.)

In the case of an emergency, staff will assess and either call 911 or refer to the parent(s)/emergency contact(s) listed for pick up or next steps. I hereby give permission to 4-H staff or program representative to obtain medical treatment for my child in the event of an emergency if I cannot be reached. I understand that I will be responsible financially for any medical charges that result from such treatment.

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

Date: _____