

NEW ENGLAND 4-H MEMBER HEALTH FORMS

Member/Volunteer Information

| | | | | |
|---------------|-------|----------------|---------|---------------------|
| Last Name | First | Middle Initial | M F | / / |
| StreetAddress | City | State | ZipCode | () HomePhoneNo. |

Notify In Case of Emergency (Emergency Contacts will be notified in order listed until one contact is reached)

| | | | |
|----------------|----------------|----------------|--------------|
| Name | Relationship | Name | Relationship |
| Address | | Address | |
| City | State | Zip Code | |
| () | () | () | () |
| Home Telephone | Work Telephone | Cell Telephone | |
| Home Telephone | Work Telephone | Cell Telephone | |

Allergies

| | | | |
|----------------------|-------------------|-----|----|
| Food (List Food) | Life Threatening? | Yes | No |
| Drug (List Drug) | Life Threatening? | Yes | No |
| Insect (List Insect) | Life Threatening? | Yes | No |
| Other (List) | Life Threatening? | Yes | No |

Personal Medical History

| | |
|---|------|
| Previous Surgery/Hospitalization? Explain. | Date |
| Physical Limitations? Explain | Date |
| Mental Health Issues Requiring Treatment? Explain | Date |
| Current Medications? List | Date |

Parent/Guardian Authorizations

I recognize that some activities have an inherent risk that could result in personal injury. The person herein described has permission to engage in all 4-H activities except as noted: Please list here:

I hereby give permission to the medical personnel to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected to secure and administer treatment, including hospitalization, for the person named above. I (we) understand that all financial obligations incurred, if not covered by insurance, will be my responsibility. This form may be photocopied for specific events. This health form will be maintained in a confidential manner.

All fairgoers & exhibitors may be photographed or filmed by our staff photographers or videographers while on our grounds. Film and Footage taken on our grounds are the property of Eastern States Exposition for possible use in its promotional materials. Entrance to our grounds precludes any and all financial compensation.

| | |
|---|------|
| Signature of Parent or Guardian | Date |
| Printed Name | Date |
| For religious reasons, my child may not be treated by a medical doctor | |
| Signature of Parent or Guardian | Date |