

2009 TEEN CONFERENCE PARTICIPANT HEALTHFORM

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Mail this form to the address below by (date) Event Address

Attendance dates: from: June 28, 2009 to June 30, 2009

Participant Name: First Middle Last

Male Female Birth Date Age on arrival at program Mont/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

- 1. Complete pages 1, 2 and 3 of this form (and make a copy for yourself). 2. Send the original, signed form to program by requested date.

Participant Home Address: Street Address City State Zip Code

Parent/guardian with residential placement and/or decision-making authority in the event of illness or injury:

Name: Relationship to Participant:

Preferred Phones: Email:

Home Address: (If different from above) Street Address City State Zip Code

Second parent/guardian with legal responsibility/authority to be contacted in case of illness or injury:

Name: Relationship to Participant:

Preferred Phones: Email:

Additional parent/guardian to be contacted in case of illness or injury:

Name: Relationship to Participant:

Preferred Phones: Email:

Allergies: No known allergies. This participant is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other (Please describe below what the participant is allergic to and the reaction seen, in detail. Please describe preventative or responsive measures.) This participant has a life-threatening allergy. An emergency care plan signed by physician is required.

Diet, Nutrition: This participant eats a regular diet. This participant eats a vegetarian diet (describe details below). This participant has special food needs. (Please describe below.)

Immunizations:

- My child is up-to-date on his/her immunizations and tetanus shots as required by Washington State law. My child has an immunization exemption on file with his/her school. I understand and accept the risks to my child from not being fully immunized.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the participant:

- 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?
3. During the past 12 months, seen a professional to address mental/emotional health concerns?
4. Had a significant life event that continues to affect the participant's life? (History of abuse, physical or sexual trauma; conduct disorders such as oppositional defiance, developmental disability, Autism Spectrum Disorder?, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)
5. Depression (Bipolar)?

Please explain "Yes" answers in the space below, noting the number of the questions. The staff may contact you for additional information.

Participant Name: First Middle Last (For Camp Use) Cabin or Group (For Program Use) Session Code(s)

<p>2009 TEEN CONFERENCE PARTICIPANT HEALTH FORM</p> <p>PAGE 2/3</p>	Participant Name: _____ <div style="display: flex; justify-content: space-around; font-size: small;"> First Middle Last </div> Birth Date: _____ <div style="display: flex; justify-content: space-around; font-size: x-small;"> Month/Day/Year </div>
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General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does this participant:

- | | | | | | |
|--|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| 1. Ever been hospitalized?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Ever had surgery?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 16. Ever had back/joint problems?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Had a recent infectious disease?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 17. Have a history of bedwetting?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Had a recent injury?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Has asthma/wheezing/shortness of breath?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 19. Have any skin problems?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have diabetes?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Had seizures?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 21. Had Sickle Cell disease or traits?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Had headaches?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 22. Had high blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 23. Had cardiovascular disease or other heart problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Had fainting or dizziness?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 24. Have a history of heart disease (not limited to conjunctive heart defect, cardiomyopathy, ahbrythemia?)..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Passed out/had chest pain during exercise?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| 13. Had mononucleosis ("mono") during the past 12 months?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

- Medication:**
- This participant will not take any daily medications while attending the activities.
 - This participant will take the following daily medication(s) while attending the activities. ¹

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **All medications must be in their original containers. Prescriptions must have the child's name and how the medication should be given printed on the prescription container. Please send only those medications that are necessary.**

Name of medication	Date started	When it is given	Amount or dose given	How it is given
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Other time: _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Other time: _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Other time: _____		

- Restrictions:**
- I have reviewed the program and activities of the program and feel the participant can participate without restrictions.
 - I have reviewed the program and activities of the program and feel the participant can participate with the following restrictions or adaptations. **(Please describe below.)**

¹ Note: These provisions regarding administration of medication shall not abrogate minors' rights to provide their own consent to certain services under Washington law.

**Washington State University
4-H Teen Conference- 2009
Emergency Medical Release**

In an emergency requiring medical attention or a situation reasonably believed by Washington State University (WSU) authorized agents including 4-H Teen Conference staff to be an emergency; I authorize WSU and its authorized agents to obtain emergency medical care for my child. I will be responsible for any expenses incurred in so doing including but not limited to care by health care professionals, hospital care, and ambulance or other services. In addition, the health care provider has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

NOTE: Minors may consent to certain services in Washington.

I hold harmless and agree to indemnify Washington State University, its authorized agents and employees and the staff of 4-H Teen Conference from decisions to seek emergency treatment.

Please complete the following:

Student Participant: _____

Date of Birth: _____

Parent or Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ E-mail: _____

Health-Care Providers:

Name of participant's primary doctor(s): _____ Phone: (____) _____

Name of dentist(s): _____ Phone: (____) _____

Name of orthodontist(s): _____ Phone: (____) _____

Additional health care provider(s) name(s) and contact numbers:

Medical Insurance Information:

This participant is covered by family medical and/or hospital insurance Yes No

Primary Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number (____) _____

Secondary Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number (____) _____

Name of another person to contact in case of emergency if you are not available:

Phone: (____) _____ E-mail: _____

Relationship to participant: _____

I voluntarily sign this authorization in consideration for permission for my child to participate in the **2009- 4-H Teen Conference** I have read it, and I understand its content and significance.

Signature of Parent/Guardian

(For participant less than 18 years of age)

Date

Signature of Participant

(For participant 18 years of age or older)

Date

WASHINGTON STATE UNIVERSITY



4-H Youth Development Program

