



# Kansas 4-H Participation Form



**Note:** This form must be completed by the participant and/or parent or guardian in order to participate in the 4-H program. **All items must be completed, even if the response is not applicable – indicate by using N/A (for example: no health insurance).** Failure to complete this form in its entirety will result in the person being ineligible to participate in 4-H activities. Please print with blue or black ink to allow for photocopying.

Name \_\_\_\_\_ County/District \_\_\_\_\_  
 Last First  
 Address \_\_\_\_\_ Birth Date \_\_\_\_\_ Age  Youth  Female  
 City \_\_\_\_\_ KS Zip \_\_\_\_\_ MM/DD/YY  Adult  Male  
 E-mail \_\_\_\_\_ Home Phone \_\_\_\_\_

Emergency Contact #1 \_\_\_\_\_ Phone HWC \_\_\_\_\_ Phone HWC \_\_\_\_\_  
 Emergency Contact #2 \_\_\_\_\_ Phone HWC \_\_\_\_\_ Phone HWC \_\_\_\_\_

Name of Family Doctor \_\_\_\_\_ Doctor's Phone \_\_\_\_\_  
 Health Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_  
 Name of Insured \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

### HEALTH HISTORY

Does the participant have, or at any time has had, any of the following? Check "Yes" or "No" to each item. Please explain any "yes" answers (noting the number of the item) in the space below or on an additional sheet of paper if necessary. Reporting conditions will not prevent a person from attending and will be kept confidential.

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1) Asthma .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Bronchitis .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Convulsions .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Diabetes .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Ear Infection .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Fainting .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Heart Condition .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Headaches .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Hypoglycemia .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Serious Insect Stings .....         | <input type="checkbox"/> | <input type="checkbox"/> |
| 11) Wear Glasses .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12) Wear Contact Lenses .....           | <input type="checkbox"/> | <input type="checkbox"/> |
| 13) Other Conditions .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| 14) Penicillin Allergy .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| 15) Aspirin Allergy .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| 16) Tetanus Allergy .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| 17) Other Drug Allergies .....          | <input type="checkbox"/> | <input type="checkbox"/> |
| 18) Food Allergies .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| 19) Serious Ivy, Oak or Sumac Poisoning | <input type="checkbox"/> | <input type="checkbox"/> |
| 20) Other Allergies .....               | <input type="checkbox"/> | <input type="checkbox"/> |
- Date of Last Tetanus Shot \_\_\_\_\_

Please explain "Yes" answers and provide information on recent medical issues (including injuries and surgeries), allergic reactions, special dietary regulations, present medications, any specific activities to be restricted and other comments.

The following over-the-counter medications may be administered to my child, without contacting me.  
 Antihistamine  Antacid  Ibuprofen (Advil)  Acetaminophen (generic, Tylenol)  
 Decongestant  Dramamine  Hydrocortisone  Polysporin (topical antibiotics)  
 Please contact me for permission to administer any over-the-counter medications.

### PUBLICITY RELEASE

I authorize K-State Research and Extension and Kansas 4-H Foundation or their assignees to record and photograph my image and/or voice (or that of my child, if under 18) for use in research, educational and promotional programs. I also recognize that these audio, video and image recordings are the property of K-State Research and Extension and/or Kansas 4-H Foundation.

No, I do not authorize use of my – or my child's – individual image or voice.

