

HEALTH HISTORY INFORMATION

(This information is confidential and will be used only in case of emergency.)

Name of 4-H Member: _____

Social Security Number: _____ Date of Birth: _____

(Optional)

Month Day Year

Is your child subject to:	Yes	No	Does your child have or has ever had:	Yes	No
Colds			Heart Trouble		
Sore Throat			Asthma		
Fainting Spells			Lung Trouble		
Bronchitis			Sinus Trouble		
Convulsions			Hernia (rupture)		
Cramps			Appendicitis		
Allergies			Has appendix been removed?		

Is the child currently under any type of medical treatment?

Is there any history of behavior disorders or emotional disturbances, such as difficulties in relationships with authority figures or peers, or abnormally severe moodiness?

Is it O.K. to administer over-the-counter medication? For example: Tylenol, Antacid, Aspirin.

Has the child been under psychiatric treatment within the past three years?

Date of child's last Tetanus Vaccination:
M. D. Y.

Please identify child's allergies, including allergies to food, medications, or drug reactions you know about:

Please list any physical disabilities or disorders that may limit your child's activities at this 4-H function, such as eyesight, hearing, speech, paralysis, diabetes, ulcer, etc.

Please list all medications that you are presently taking:

Name of Medication	Dosage	Times Taken

Remarks and any special instructions. Please explain "Yes" answers on this page.

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