

**Texas 4-H Youth Development Program**  
**HEALTH AND SAFETY STATEMENT**

Check one:  Youth  Adult County: \_\_\_\_\_  
Event: \_\_\_\_\_ Event Dates: \_\_\_\_\_

**Section I. Participant Information**

First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Gender: \_\_\_\_\_  
Last Name: \_\_\_\_\_ Name of Physician: \_\_\_\_\_  
Address: \_\_\_\_\_ Physician's Number: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Section II. Emergency Contact Information**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Section III. Health History (Check the appropriate answer and explain any YES responses.)**

Have you had or do you currently have any heart problems (dates): \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
Do you frequently suffer from pains in your chest: \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
*(NOTE: If you have any heart related problems you will need to have a physician's release.)*  
Do you often feel faint or have spells of severe dizziness: \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
Has a doctor ever told you that you might have high blood pressure: \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
Are you a smoker: \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
Do you have arthritis, joint, or back problems that can be aggravated by exercise: \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
Have you had any operations or serious injuries (dates): \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
Do you have any chronic recurring illness or communicable diseases: \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
Are there any activities to be limited/discouraged by a physician's advice: \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
Are you allergic to any medications, food or food ingredients, insects, or pollens: \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
Do you have Epilepsy: \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
Do you have Diabetes: \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
Do you have any prescribed meal plan or dietary restrictions (explain) \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
Any other health related information for 4-H personnel to be aware of: \_\_\_\_\_ Yes \_\_\_ No \_\_\_

**Section IV: Medications (ALL medications must be in ORIGINAL container with ORIGINAL LABEL.)**

Are there prescribed or over-the-counter medications currently being taken \_\_\_\_\_ Yes \_\_\_ No \_\_\_

**Section V. Insurance Information – Please provide a copy of your insurance card.**

Do you carry family medical/hospital insurance? \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
Carrier: \_\_\_\_\_ Policy \_\_\_\_\_

**Section VI. Release of Participant (If minor)**

I/We do hereby authorize the release of said minor child to the following person/people at the conclusion:  
(please list all persons, including parents)

Further, I/We require that said minor child NOT be released to the following person/people at the conclusion of the activity:

**Section VII. Health and Safety Statement Certification**

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand this information is confidential and is to be used only by AgriLife Extension Staff or designated Volunteers for health and safety reasons. I hereby consent to the use of this information for such purposes.

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_  
*Or guardian if participant is under the age of 18)*