

This form is to be completed and signed by the applicant, or if under 18, by a parent or guardian. Accurate and complete information is required to ensure adequate supervision and protection while at the program. This information is confidential and will be available only to 4-H staff administering the program and a physician, if necessary.

The parent or guardian assumes full responsibility for the participant's health and ensuring that program activities will not aggravate any existing condition. **It is assumed that the parent or guardian knows the child's condition or will seek competent advice before completing the form.** The parent or guardian will notify the program director if, for any reason, this permission should be withdrawn or changed. **Note: Every care and attention will be given to the health and comfort of the participants. However, neither the program coordinator in charge, nor the provincial government shall be held responsible for any accidents that may occur.**

Participant's last name		First name	Initial
Mailing address		Town or city	
Postal code	Home phone	Date of birth (yy/mm/dd)	
Alberta Health Care number		Blue Cross number	
Physician's name		Phone number	
Emergency contact name		Relationship	
Home phone	Business phone	Other phone	

Note: The program coordinator must be able to contact this person at all times during the program.

Conditions Check (✓) any of the following conditions the participant has been diagnosed with or frequently has:

- | | | | |
|--------------------------------------|-------------------------------------------------|------------------------------------------|---------------------------------------------------------------|
| Asthma <input type="checkbox"/> | Epilepsy <input type="checkbox"/> | HIV <input type="checkbox"/> | Skin condition <input type="checkbox"/> |
| Bed Wetting <input type="checkbox"/> | Eye trouble <input type="checkbox"/> | Kidney trouble <input type="checkbox"/> | Sinus trouble <input type="checkbox"/> |
| Bronchitis <input type="checkbox"/> | Fainting <input type="checkbox"/> | Migraines <input type="checkbox"/> | Sleep walking <input type="checkbox"/> |
| Convulsions <input type="checkbox"/> | Frequent colds <input type="checkbox"/> | Motion sickness <input type="checkbox"/> | Tonsillitis <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Fetal Alcohol Syndrome <input type="checkbox"/> | Nightmares <input type="checkbox"/> | Attention Deficit Disorder <input type="checkbox"/> |
| Ear trouble <input type="checkbox"/> | Heart Conditions <input type="checkbox"/> | Rheumatism <input type="checkbox"/> | Attn. Deficit Hyperactivity Disorder <input type="checkbox"/> |

Please give details of usual treatment if indicated condition(s) should occur.

List all medications (prescription and non-prescription) that the participant uses:

Name of drug _____	Dosage: _____
Name of drug _____	Dosage: _____
Name of drug _____	Dosage: _____
Name of drug _____	Dosage: _____

- Medications must be clearly labelled and stored in a prescription container or dosette with separate sections for each day's dosage. (Dosettes are available at your local pharmacy.)
- If the delegate is 14 or younger:
 1. on arrival at the program the medication must be given to the first aid person **or**
 2. the participant must have written permission to administer his/her own medications

Allergies Specify any allergies the participant has (for example: drugs, food, animals, plants or insect stings). Describe signs or symptoms and treatment required.

Does the participant have: an inhaler anakit D epi-pen
 Does the participant know how to use it? No Yes
 Will he/she have it accessible at all times? No Yes

Date of last tetanus immunization: _____ (yy/mm)

Give dates and nature of recent operations and injuries. Specify any precautions that have been advised.

The program may include rigorous activities. Does the participant suffer from any physical or emotional disorder that would prevent full participation in this program? No Yes If yes, state particulars.

(add additional page if necessary)

As the participant named on the front, or parent or guardian of that participant, I hereby authorize the leader-in-charge of the program to seek medical advice and services deemed necessary for the health and safety of myself, or my child or ward, under the circumstances listed below:

- Where the health and well being of the participant is involved.
- Where medical advice suggests that more services are required which need the consent of the parent or guardian.
- Where all attempts to contact the parent or guardian have failed or where due to the nature of the emergency there is insufficient time to contact the parent or guardian, the leader-in-charge of the program shall determine what steps must be taken for the welfare and safety of the participant.



I declare the above information is complete and correct to the best of my knowledge. Also, I agree to accept financial responsibility for any medical services in excess of the benefits allowed by any medical insurance coverage the participant may have.

Participant's Signature	Date
Parent/Guardian Signature <i>[Required for all members under 18 years]</i>	Date

- Bring this 4-H Personal Health Record to the program or return as directed by the program coordinator.
- Participants are not allowed to leave the program without the permission of the program coordinator. If your child or ward is to leave the program for any reason, please request this in writing prior to the program.

Personal information on this form is used for administration of the 4-H program under the authority of the *Freedom of Information and Protection of Privacy Act*. Information provided is protected under the *Freedom of Information and Protection of Privacy Act*. If you need more information, contact the provincial 4-H office at 780-422-4H4H (4444). AG0265 Rev. 05-09/cas