

HEALTH STATEMENT

District 7 Leadership Lab

Check one: _____ Youth _____ Adult County: _____
Gender (check one): _____ Male _____ Female

The proposed activity provided by the Texas 4-H Youth Development Program, requires participation in physical exercises, which are, by their nature, physically demanding. Many of the activities will challenge you, and cause surges in blood pressure and pulse rates. It is imperative that you are free of any heart related or other disease. Therefore, all participants must be free of medical or physical conditions which might create undue risks to themselves or any others who depend on them. If there is any doubt about your ability to safely participate in this experience, you should have a physical examination.

Section I. Participant Information

Name _____ Date of Birth _____ Age _____
Address _____ Name of Physician _____
City, State, Zip _____ Physician's Phone _____
Home Phone _____ Date of last physical exam _____

Section II. In the event of an Emergency, please contact:

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 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 (please describe) _____ YES _____ NO _____

Are all immunizations up-to-date: _____ YES _____ NO _____

Date of last Tetanus shot (required) _____

Any other health related information for camp personnel to be aware of: _____

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

Are there prescribed medications currently being taken? (please describe): _____ YES _____ NO _____

Please check "over the counter" medications which camp personnel may administer as necessary:

_____ Immodium	_____ Pepto Bismol	_____ Ibuprofen (Motrin)	_____ Acetaminophen (Tylenol)
_____ Neosporin	_____ Benadryl	_____ Robitussin DM or CF	_____ Any as needed

Participant Signature _____ Guardian Signature _____