Beyond This Moment
2020 4-H ʻAhaʻōlelo Conference
July 13-July 16, 2020
Hilo, Hawaiʻi

CONFIDENTIAL **HEALTH FORM** ***CONFIDENTIAL***

COMPLETE FOR EACH PARTICIPANT

Parent's Statement: Please complete and send in with your registration

Name of Delegate: _____ _____ _____
LAST FIRST MIDDLE

Birth Date: _____ *Gender:* _____ _____
Month Day Year Male Female

Parent/Guardian: _____ *Home Phone:* _____

Cell Phone: _____ *Work Phone:* _____

Alternate Emergency Contact: _____
Name

Alternate Emergency Phone: _____
Phone Number

I am of the opinion that _____ can **SAFELY PARTICIPATE** in the 4-H ʻAhaʻōlelo Conference and that he or she has no contagious or communicable diseases. His or her health is **POOR FAIR GOOD** (strike out words that do not apply) and he or she has had no illnesses within 30 days prior to departure to the event. In case of emergency while participating in 4-H ʻAhaʻōlelo Conference, permission is given for physicians to perform needed treatment. I will assume all financial obligations incurred if not covered by insurance.

Parent's/Guardian Signature _____

HEALTH FORM

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If the answer is "*yes*" to any of the following, enter the details in the space provided indicating the diagnosis, date of illness, name of hospital, length of hospitalization, name of doctor, etc.

		Yes	No
1	NERVOUS OR MENTAL Problems such as epilepsy, emotional stress, convulsions, loss of consciousness, dizziness, paralysis, frequent anxiety, excessive crying. *If yes, please explain:*		
2	LUNG DISEASE Asthma, blood spitting, persistent cough, tuberculosis, abnormal chest x-rays. *If yes, please explain:*		
3	DISEASE OR HEART OR BLOOD VESSELS, INCREASED OR ABNORMAL BLOOD PRESSURE I*f yes, please explain:*		
4	PAIN IN THE CHEST OR SHORTNESS OF BREATH Heart murmur, rheumatic fever *If yes, please explain:*		
5	STOMACH OR INTESTINAL TROUBLE Food sensitivities, ulcers, gall bladder or liver disorders, jaundice, hernia, colitis. *If yes, please explain:*		
6	ARTHRITIS, DIABETES, KIDNEY OR BLADDER DISEASE *If yes, please explain:*		
7	HAY FEVER OR ALLERGIES *If yes, please explain:*		
8	ALLERGIES TO MEDICINES (including Penicillin, Tetanus) *If yes, please explain:*		
9	IMPAIRED SIGHT OR HEARING, CHRONIC EAR INFECTIONS *If yes, please explain:*		
10	RECENT SURGICAL OPERATIONS, ACCIDENTS OR INJURIES *If yes, please explain:*		
11	ANY INFECTIOUS DISEASE OR CONTACT WITH INFECTIOUS DISEASE IN THE TWO WEEKS PRIOR TO THIS TRIP. *If yes, please explain:*		
12	SKIN DISEASE *If yes, please explain:*		
13	ALLERGY TO FOODS *If yes, please explain severity in detail. Add pages if necessary:*		
14	MEDICATIONS YOU ARE CURRENTLY TAKING (list name and doses) *If yes, please explain:*		
15	UNDER ON-GOING CARE OF A PHYSICIAN FOR CHRONIC OR RECURRING PROBLEM (Name and number of physician) *If yes, please explain:*		
16	LIST ANY SPECIAL NEEDS OR CONCERNS *(Attach additional page if need more space)*		