Form Y-2
Revised
7/2012

MEDICAL INFORMATION SUMMARY
For Minors in the 4-H Program

Name_____
Last First Middle

Mailing Address_____
Number & Street City, State, Zip

Date of Birth_____ Sex_____ Age_____ Phone_____

Name of parent or legal guardian _____

Parent phone during this program: Home_____Bus _____Cell _____

Email_____

Name of two alternates (relatives or friends) who may be contacted in case parent or legal guardian cannot be reached in an emergency

Name_____Relationship_____ Phone_____

Name_____Relationship_____ Phone_____

Name of child's physician_____ Phone_____

Date last seen by physician_____Reason_____

Give name and identification number of hospital/medical insurance_____

Policyholder's name _____ Agent _____

GENERAL HEALTH & MEDICAL HISTORY:

If participant has been under the care of a physician within the past 12 months or if there is any question about activity restriction, attach a statement from a physician indicating restrictions and noting any pertinent recommendations.

1. Any operations, serious injuries or chronic illness: Yes _____ No _____

   If yes, please specify:_____

2. Check communicable diseases to date:

   Measles___ Mumps ___ Chicken Pox ___
   German Measles (Rubella)____ Others_____

3. Note any communicable diseases minor have been exposed to in the last two weeks:
   _____

4. Give year of last immunization or booster for

   Tetanus _____ German Measles (Rubella)_____ Diphtheria_____
   Measles_____ Mumps _____ Polio _____ Other _____

5. Indicate any known allergies:

Food_____ Drugs _____
Plants _____ Animals _____
Insects_____ Others _____
Explain reaction and indicate medication used_____
(Medication for above should be brought with you.)

6. Check if prone to any of the following conditions:

Asthma or respiration problems ☐ Fainting ☐ Stomach upset ☐
Frequent headaches ☐ High blood pressure ☐ Heart problems ☐
Restlessness or sleepwalking ☐ Convulsions ☐ Other (please specify) _____
If you have checked any, please give details

7. List medication(s) and use, including insulin. (Should be in original container with prescription and/or label.)
Medication_____used for _____When taken _____

Medication_____used for_____When taken_____

Medication_____used for_____When taken_____

Does youth require help with medication? _____

Is refrigerator needed? Please explain_____

8. Any known physical, mental, social difficulties or other special information which may affect participation or for which special consideration should be given? (yes) (no)

Explain_____

9. Any prior activity restriction? ☐ (yes) ☐ (no) If yes, specify _____

10. Any present activity restriction desired by participant, his or her parent, guardian or physician? _____
If yes, describe _____

MEDICAL CONSENT FORM

I/We, the undersigned, consent to and authorize any medical professional and others working under their supervision to treat me for any injury or illness arising from or related to my participation in the above named program.

I/We further agree to pay any and all medical expenses, costs and other charges and to release and discharge and hold harmless the University of Hawai'i, State of Hawai'i, its officers, employees, agents, and assigns from and against any liability or any claims or demands arising from or connected with such medical treatment or care.

_____ _____
Signature of Parent (if participant is under 18 years of age) Date

IN CASE OF EMERGENCY:

First Person to Contact: _____ Phone: _____

Second Person to Contact: _____Phone: _____

Physician to Contact: _____ Phone: _____

_____ _____
Signature of Parents/Guardian(s) Date

_____
Print Name(s)