


PARTICIPANT HEALTHFORM
 For all
Spokane County 4-H Horse CAMPS
May be used by adults as well

**WSU-Extension
 Spokane County 4-H
 Clubs**



Attendance dates: from: _____ to _____

Participant Name: _____
First Middle Last

Male Female Birth Date _____ Age on arrival at program _____
Mont/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1. Complete pages 1, 2 and 3 of this form (and make a copy for yourself).
2. Send the original, signed form to program by requested date.

Participant Name: _____
First _____
Middle _____
Last _____
 (For Camp Use) Cabin or Group _____
 (For Program Use) Session Code(s) _____

Participant Home Address: _____
Street Address City State Zip Code

Parent/guardian with residential placement and/or decision-making authority in the event of illness or injury:

Name: _____ Relationship to Participant: _____
 Preferred Phones: (_____) _____ (_____) _____ Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian with legal responsibility/authority to be contacted in case of illness or injury:

Name: _____ Relationship to Participant: _____
 Preferred Phones: (_____) _____ (_____) _____ Email: _____

Additional parent/guardian to be contacted in case of illness or injury:

Name: _____ Relationship to Participant: _____
 Preferred Phones: (_____) _____ (_____) _____ Email: _____

Allergies: No known allergies. This participant is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the participant is allergic to and the reaction seen, in detail. Please describe preventative or responsive measures.)
 This participant has a life-threatening allergy. An emergency care plan signed by physician is required

Diet, Nutrition: This participant eats a regular diet. This participant eats a vegetarian diet (describe details below).
 This participant has special food needs. *(Please describe below.)*

Completion of this "grayed" section is optional depending on what you deem necessary for 4-H staff/volunteers & care-givers to know

Immunizations:

My child is up-to-date on his/her immunizations and tetanus shots as required by Washington State law.

My child has an immunization exemption on file with his/her school. I understand and accept the risks to my child from not being fully immunized.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the participant:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?..... Yes No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... Yes No
4. Had a significant life event that continues to affect the participant's life?..... Yes No
(History of abuse, physical or sexual trauma; conduct disorders such as oppositional defiance, developmental disability, Autism Spectrum Disorder?, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)
5. Depression (Bipolar)?..... Yes No

Please explain "Yes" answers in the space below, noting the number of the questions. The staff may contact you for additional information.

<p>EVENT NAME PARTICIPANT HEALTH FORM</p> <p>PAGE 2/3</p>	<p>Participant Name: _____</p> <p style="text-align: center; font-size: small;">First Middle Last</p> <p>Birth Date: _____</p> <p style="text-align: center; font-size: x-small;">Month/Day/Year</p>
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General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does this participant:

- | | |
|--|---|
| <p>1. Have recurrent/chronic illnesses?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Had a recent infectious disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Had a recent injury?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Has asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have diabetes?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Had seizures?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Had headaches?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Had fainting or dizziness?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Passed out/had chest pain during exercise?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have problems with falling asleep/sleepwalking?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Had cardiovascular disease or other heart problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>14. Have a history of heart disease (not limited to conjunctive heart defect, cardiomyopathy, abrythemia?)..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. If female, have problems with periods/menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Ever had back/joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Had Sickle Cell disease or traits?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Had high blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Ever been hospitalized?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Ever had surgery?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Had mononucleosis ("mono") during the past 12 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|---|

In the section below—please answer only those questions which you deem necessary for 4-H staff/volunteers & caregivers to know

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

- Medication:**
- This participant will not take any daily medications while attending the activities.
- This participant will take the following daily medication(s) while attending the activities.¹

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **All medications must be in their original containers. Prescriptions must have the child's name and how the medication should be given printed on the prescription container. Please send only those medications that are necessary.**

Name of medication	Date started	When it is given	Amount or dose given	How it is given
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Other time: _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Other time: _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Other time: _____		

- Restrictions:**
- I have reviewed the program and activities of the program and feel the participant can participate without restrictions.
- I have reviewed the program and activities of the program and feel the participant can participate with the following restrictions or adaptations. **(Please describe below.)**

¹ Note: These provisions regarding administration of medication shall not abrogate minors' rights to provide their own consent to certain services under Washington law.

