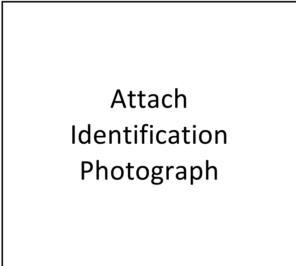
FORM 15

"Become a Catalyst of Change"

2011 National 4-H Congress
November 25 – 29, 2011
Atlanta, Georgia



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

DELEGATE HEALTH FORM

BRING TWO COPIES PER DELEGATE OR CHAPERONE

Parent's Statement: To be filled out **after November 1st**. Delegates must present this sheet to a State delegate chaperone, before delegate can be registered onsite for National 4-H Congress.

Name of Delegate: ______________________ ______________________ ______________________
LAST FIRST MIDDLE

Birth Date: ______________________ *Gender:* ________ ________
Month Day Year Male Female

Home Address: ____
Number and Street/PO Box

____
City/State/Zip Code

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 National 4-H Congress 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. In case of emergency while participating in National 4-H Congress, 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 ____

____
Notary Public

State of: ______________________ County of: ______________________

Sworn to and subscribed to before me this ______ day of ________ , 20 ____

My commission expires ______________________ , 20 ____________

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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 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	BEEN A PATIENT IN A HOSPITAL (other than #10) *If yes, please explain:*		
12	ANY INFECTIOUS DISEASE OR CONTACT WITH INFECTIOUS DISEASE IN THE TWO WEEKS PRIOR TO THIS TRIP. *If yes, please explain:*		
13	SKIN DISEASE *If yes, please explain:*		
14	ALLERGY TO FOODS *If yes, please explain:*		
15	MEDICATIONS YOU ARE CURRENTLY TAKING (list name and doses) *If yes, please explain:*		
16	UNDER ON-GOING CARE OF A PHYSICIAN FOR CHRONIC OR RECURRING PROBLEM (Name and number of physician) *If yes, please explain:*		

17 DATE OF LAST FLU SHOT: DATE OF LAST TETANUS BOOSTER:

18 LIST ANY SPECIAL NEEDS OR CONCERNS *(Attach additional page if need more space)*