

**Texas 4-H Youth Development Program**  
**HEALTH AND SAFETY STATEMENT**

Check one:  Youth  Adult County: \_\_\_\_\_ District: \_\_\_\_\_  
Event: 2023-24 D5 Junior Leadership Lab Event Dates: October 13-14, 2023

**Section I. Participant Information**

First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
Last Name: \_\_\_\_\_ Name of Physician: \_\_\_\_\_  
Address: \_\_\_\_\_ Physician's Number: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Section II. Emergency Contact Information**

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 had 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? \_\_\_\_\_ Yes  No   
Any other health related information for 4-H personnel to be aware of? \_\_\_\_\_ Yes  No

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

Are there prescribed or over-the-counter medications currently being taken? Describe. \_\_\_\_\_ Yes  No

**Section V. Insurance Information – Please provide a copy of your insurance card.**

Do you carry family medical/hospital insurance? \_\_\_\_\_ Yes  No   
Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Section VI. Release of Participant (If minor)**

I/We do hereby authorize the release of said minor child to the following person/people at the conclusion:  
(please list all persons, including parents)

Further, I/We require that said minor child NOT be released to the following person/people at the conclusion of the activity:

**Section VII. Health and Safety Statement Certification**

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand this information is confidential and is to be used only by AgriLife Extension Staff or designated Volunteers for health and safety reasons. I hereby consent to the use of this information for such purposes.

Participant OR Parent/Guardian Name (if participant is under the age of 18): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_