TEXAS A&M AGRILIFE EXTENSION

Texas 4-H Youth Development Program
HEALTH AND SAFETY STATEMENT
2024 SENIOR LEADERSHIP LAB

HSS 09.01.2020

Check one: ___ Youth ___ Adult **County:** _____ **District:** _____

Event: _____ **Event Dates:** _____

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:** _____