

# TEXAS 4-H YOUTH DEVELOPMENT FORM HSS - HEALTH AND SAFETY STATEMENT 2025-2026



Revised: 6/2025

Check One: ☐ Youth ☐ Adult

County: \_\_\_\_\_ District: \_\_\_\_\_

Event: \_\_\_\_\_

Event Dates: \_\_\_\_\_

## Section I. Participant Information

First Name: \_\_\_\_\_

Gender: ☐ Female ☐ Male

Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_

Address: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Physician's Number: \_\_\_\_\_

Phone Number: ( ) -

Date of last physical exam: \_\_\_\_\_

## Section II. Emergency Contact Information

Contact Name #1: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact Name #1: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Numbers: ( ) - ( ) - Phone Numbers: ( ) - ( ) -

Address: \_\_\_\_\_ Address: \_\_\_\_\_

## Section III. Health History (Check the appropriate answer; if YES, use space to the right to provide additional information)

Have you had any operations or injuries that impede participation?

☐ No ☐ Yes \_\_\_\_\_

Are there any activities to be limited/discouraged by a physician's advice?

☐ No ☐ Yes \_\_\_\_\_

Have you had or do you currently have any heart problems?

☐ No ☐ Yes \_\_\_\_\_

Do you require any accommodation to participate in scheduled activities?

☐ No ☐ Yes \_\_\_\_\_

Do you have any chronic recurring illness or communicable diseases?

☐ No ☐ Yes \_\_\_\_\_

Are you allergic to any medications, food or food ingredients, insects, or pollens?

☐ No ☐ Yes \_\_\_\_\_

Do you require an inhaler, epinephrine injector, or other item that you keep at all times?

☐ No ☐ Yes \_\_\_\_\_

Do you have a medically prescribed meal plan or dietary restrictions?

☐ No ☐ Yes \_\_\_\_\_

Do you have Epilepsy?

☐ No ☐ Yes \_\_\_\_\_

Do you have Diabetes?

☐ No ☐ Yes \_\_\_\_\_

List any other health related information:

☐ No ☐ Yes \_\_\_\_\_

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

Are there prescribed or over-the-counter medications currently being taken? ☐ No ☐ Yes

If yes, please describe: \_\_\_\_\_

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

Do you carry family medical/hospital insurance? ☐ No ☐ Yes

Carrier: \_\_\_\_\_ Policy: \_\_\_\_\_

## Section VI. Release of Participant (If minor) at conclusion of activity/camp/event/program

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

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

## 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 Certification

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Parent/Guardian Certification (only if participant is under the age of 18)

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Programs with multiple dates/sessions. I certify this information is correct.

Date: \_\_\_\_\_ Initial: \_\_\_\_\_ Date: \_\_\_\_\_ Initial: \_\_\_\_\_