

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



Revised: 6/2025

Check One:  Youth  Adult  
Event: \_\_\_\_\_

County: \_\_\_\_\_ District: \_\_\_\_\_  
Event Dates: \_\_\_\_\_

**Section I. Participant Information**

First Name: \_\_\_\_\_  
Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone Number: (      ) -      -

Gender:  Female  Male  
Date of Birth:      /      /      Age: \_\_\_\_\_  
Name of Physician: \_\_\_\_\_  
Physician's Number: \_\_\_\_\_  
Date of last physical exam: \_\_\_\_\_

**Section II. Emergency Contact Information**

Contact Name #1: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone Numbers: (      ) -      (      ) -      -  
Address: \_\_\_\_\_

Contact Name #1: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone Numbers: (      ) -      (      ) -      -  
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?  
Are there any activities to be limited/discouraged by a physician's advice?  
Have you had or do you currently have any heart problems?  
Do you require any accommodation to participate in scheduled activities?  
Do you have any chronic recurring illness or communicable diseases?  
Are you allergic to any medications, food or food ingredients, insects, or pollens?  
Do you require an inhaler, epinephrine injector, or other item that you keep at all times?  
Do you have a medically prescribed meal plan or dietary restrictions?  
Do you have Epilepsy?  
Do you have Diabetes?  
List any other health related information:

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
<input type="checkbox"/>	No	<input type="checkbox"/>	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.

<b>Participant Certification</b>	
Printed Name: _____	
Signature: _____	
Date: _____	

<b>Parent/Guardian Certification (only if participant is under the age of 18)</b>	
Printed Name: _____	
Signature: _____	
Date: _____	

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

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