

***PRINCE EDWARD ISLAND 4-H PROGRAM
HEALTH INFORMATION FORM***

This form is to be signed and completed by a parent or guardian and returned with the Participant's Conduct Form and registration fee. Accurate and complete information is essential. These forms are confidential and will be available only to 4-H staff and a physician, if necessary. The parent or guardian is assuming full responsibility for the participant's health being such that the program activities will in no way aggravate any condition present. This program may be of a strenuous nature both physically and mentally.

Name of Participant _____
(surname) (first) (middle)

Mailing Address _____ Postal Code _____

Home Phone _____ Date of Birth _____

In Emergency Notify _____ Relationship _____

Address _____

Home Phone _____ Business Phone _____

Doctor's Name _____ Phone _____

Health Card Number (Not S.I.N.) _____ Expiry Date _____

Other Hospital Insurance _____

PERSONAL HEALTH RECORD

Check any of the following conditions which the participant is subject to:

- | | | |
|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Eye Trouble | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Boils | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Ear Trouble | <input type="checkbox"/> Hysteria |
| <input type="checkbox"/> Skin Condition (contagious) | <input type="checkbox"/> Skin Condition (non-contagious) | <input type="checkbox"/> Nightmares |
| | | <input type="checkbox"/> Sleep Walking |

Please give details of usual treatment should said condition occur:

Other medical concerns (e.g. Diabetes) of which the program staff should be made aware?
(Specify - give details of medication necessary.)

Check any of the following allergies which the participant is subject to:

- | | | | |
|----------------------------------|----------------------------------|--|--------------------------------|
| <input type="checkbox"/> animals | <input type="checkbox"/> drugs | <input type="checkbox"/> dusts | <input type="checkbox"/> foods |
| <input type="checkbox"/> plants | <input type="checkbox"/> pollens | <input type="checkbox"/> insect stings | <input type="checkbox"/> other |

Specify: _____

Signs/Symptoms: _____

Treatment: _____

Check any of the following illnesses which the participant has had:

<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> German Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Pneumatic Fever	<input type="checkbox"/> Whooping Cough

Any illness or disability not included on this list:

Recent operations and injuries (give dates and nature): _____

Precautions that have been advised: _____

Date of last tetanus immunization: _____

The program may include rigorous activities. Does the applicant suffer from any physical or emotional disorders that would prevent full participation in this program? Yes No
(if yes, state particulars) _____

Is the participant currently taking medication? Yes No

Name of Drug: _____ Dosage: _____

Condition for which drug was prescribed: _____

As the parent/guardian of the participant, under circumstances as stated below, I hereby authorize the leader in charge of the program to secure such medical advice and treatment as may be deemed necessary for the health and safety of my child or ward, _____, and I agree to accept financial responsibility in excess of the benefits allowed by the Provincial Health Plan:

1. Where the health and well-being of the participant is involved.
2. Where medical advice has been such that further services are required - services which require the consent of parent/guardian.
3. Where all attempts to contact the parent/guardian have failed, or where due to the nature of the emergency there is insufficient time to contact such parent/guardian, it will be at the discretion of the leader in charge of the program to decide what steps must be taken for the welfare and safety of the delegate.

(Date)

(Signature of Parent/Guardian)

The Prince Edward Island and Canadian 4-H Councils protect your personal information by adhering to all legislative requirements with respect to privacy. We use your information to provide services, to keep you informed about 4-H activities, for statistical and research purposes, to satisfy government and regulatory obligations and we may contact you from time to time regarding new 4-H initiatives. If you at any time wish to be removed from our database, simply contact us by phoning the PEI 4-H - 368-4833.