|  |  |
| --- | --- |
| ***Courage to Grow, Heart to Serve***  2024 National 4-H Congress  November 29 – December 3, 2024  Atlanta, Georgia | ***Attach Identification Photograph*** |

***DELIGATE HEALTH FORM* (**form 15**)**

BRING TWO COPIES PER DELEGATE & CHAPERONE

|  |  |
| --- | --- |
| State/LGU |  |

|  |  |
| --- | --- |
| Parent’s Statement | To be filled out **after November 1st**. Delegates must present this sheet to a State/LGU delegate chaperone before delegate can be registered onsite for National 4-H Congress. |

**CONFIDENTIAL**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Delegate’s Full Name: |  | | | |
| Date of Birth (month/day/year): | |  | | |
| Gender (male/female): | |  | | |
| Home Address: | |  | | |
| City/State/Zip: | |  | | |
| Parent /Guardian: | |  | | |
| Parent/Guardian Cell Phone Number: | |  | | |
| Parent/Guardian Home Phone Number: | |  | | |
| Alternate Emergency Contact: | |  | | |
| Alternate Emergency Phone # | |  | | |
|  | |  | | |
| I am of the opinion that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ can **SAFELY PARTICIPATE** in National 4-H Congress and that he or she has no contagious or communicable diseases. His or her health is **POOR FAIR GOOD** (strike out words that do not apply) and he or she has had no illnesses within 30 days prior to departure. In case of emergency while participating in National 4-H Congress, permission is given for physicians to perform needed treatment. I will assume all financial obligations incurred if not covered by insurance. | | | |
| *Parent’s/Guardian Signature* | | |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DELEGATE HEALTH FORM (FORM 15– PAGE 2)** | | | |  | | | | | | | |
|  | |  | |  | | |  |  | | | |
| ***CONFIDENTIAL*** | | | | | | | | | | | |
| If the answer is "*yes"* to any of the following, enter the details in the space provided indicating the diagnosis, date of illness, name of hospital, length of hospitalization, name of doctor, etc. | | | | | | | | | | | |
|  |  | | |  | | | | | YES | | NO |
| 1 | NERVOUS OR MENTAL | | |  | | | | |  | |  |
|  | Problems such as epilepsy, emotional stress, convulsions, loss of consciousness, dizziness, paralysis, Frequent anxiety, excessive crying. *If yes, please explain:* | | | | | | | |  | |  |
| 2 | LUNG DISEASE | | |  | | | | |  | |  |
|  | Asthma, blood spitting, persistent cough, tuberculosis, abnormal chest x-rays. *If yes, please explain:* | | | | | | | |  | |  |
| 3 | DISEASE OR HEART OR BLOOD VESSELS, INCREASED OR ABNORMAL BLOOD PRESSURE I*f yes, please explain:* | | | | | | | |  | |  |
| 4 | PAIN IN THE CHEST OR SHORTNESS OF BREATH | | | | | | | |  | |  |
|  | Heart murmur, rheumatic fever *If yes, please explain:* | | | | | | | |  | |  |
| 5 | STOMACH OR INTESTINAL TROUBLE | | |  | | | | |  | |  |
|  | Food sensitives, ulcers, gall bladder or liver disorders, jaundice, hernia, colitis. *If yes, please explain:* | | | | | | | |  | |  |
| 6 | ARTHRITIS, DIABETES, KIDNEY OR BLADDER DISEASE *If yes, please explain:* | | | | | | | |  | |  |
| 7 | HAY FEVER OR ALLERGIES *If yes, please explain:* | | | | | | | |  | |  |
| 8 | ALLERGIES TO MEDICINES (including Penicillin, Tetanus) *If yes, please explain:* | | | | | | | | |  |  |
| 9 | IMPAIRED SIGHT OR HEARING, CHRONIC EAR INFECTIONS *If yes, please explain:* | | | | | | | | |  |  |
| 10 | RECENT SURGICAL OPERATIONS, ACCIDENTS OR INJURIES *If yes, please explain:* | | | | | | | | |  |  |
| 11 | BEEN A PATIENT IN A HOSPITAL (other than #10) *If yes, please explain:* | | | | | | | | |  |  |
| 12 | ANY INFECTIOUS DISEASE OR CONTACT WITH INFECTIOUS DISEASE IN THE TWO WEEKS PRIOR TO THIS TRIP. *If yes, please explain:* | | | | | | | | |  |  |
| 13 | SKIN DISEASE *If yes, please explain:* | | | |  | | | | |  |  |
| 14 | ALLERGY TO FOODS *If yes, please explain in detail. Add pages if necessary:* | | | | | | | | |  |  |
| 15 | MEDICATIONS YOU ARE CURRENTLY TAKING (list name and doses) *If yes, please explain:* | | | | | | | | |  |  |
| 16 | UNDER ON-GOING CARE OF A PHYSICIAN FOR CHRONIC OR RECURRING PROBLEM (Name and number of physician) *If yes, please explain:* | | | | | | | | |  |  |
| 17 | DATE OF LAST FLU SHOT: | |  | | | DATE OF LAST TETANUS BOOSTER: | | | |  | |
| 18 | LIST ANY SPECIAL NEEDS OR CONCERNS *(Attach additional page if need more space)* | | | | | | | | |  |  |
|  |  | | | | | | | | | | |