Health and Emergency Information

*** This form is for Individual Group use only if they do not have their own Health and Emergency Form. It does not need to be handed in for CWF participation!**

Participant Last Name: _____ First Name: _____
Emergency Contact Information (include parent or guardian):

Contact #1:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Contact #2:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

In case of emergency, I (We) hereby authorize designated representatives of the Citizenship Washington Focus program to consent on my behalf to medical treatment and/or hospital care as advised and deemed necessary by emergency medical staff, physicians or surgeons. I (We) also understand that all financial obligations incurred, if not covered by insurance, will be my responsibility.

Additionally, I (We) have also read and noted that in case of emergency while attending Citizenship Washington Focus, participants may be contacted as follows:
Delegate's Name
CWF Week #
National 4-H Conference Center
7100 Connecticut Avenue
Chevy Chase, MD 20815
Phone: (301) 961-2801.

I (We) agree that this participant can safely attend Citizenship Washington Focus.

Participant's Signature: _____ Date:_____

Parent/Guardian's Signature: _____ Date: _____

Participant Name: _____
Date of last flu shot: _____ Date of last tetanus booster: _____
Please indicate "yes" or "no" for each of the following. If "yes" enter details indicating diagnosis, date of illness, name of hospital, length of hospitalization, name of doctor, and any other pertinent information.

	Yes	No
Nervous or Psychological Problems such as epilepsy, emotional stress, convulsions, loss of consciousness, dizziness, paralysis, frequent anxiety, excessive crying.	☐	☐
Lung Disease Asthma, blood spitting, persistent cough, tuberculosis, abnormal chest x-rays.	☐	☐
Disease of Heart or Blood Vessels, increased or abnormal blood pressure	☐	☐
Stomach or Intestinal Trouble Ulcers, gall bladder or liver disorder, jaundice, hernia, colitis	☐	☐
Arthritis, Diabetes, Kidney or Bladder Disease	☐	☐
Hay Fever or Allergies	☐	☐
Allergies to Medicines (including penicillin, tetanus)	☐	☐
Impaired site or hearing, chronic ear infections	☐	☐
Recent surgical operations, accidents or injuries	☐	☐
Been a patient in a hospital (other than a recent surgical operation)	☐	☐
Any infectious disease or contact within the past two months	☐	☐
Skin Disease	☐	☐
Allergy to Foods (please be sure to notify 4-H staff of special dietary needs)	☐	☐
Under on-going care of a physician for chronic or recurring problem	☐	☐

Currently taking medicines (list names and doses)

_____

_____

Please list any special assistance needed, such as dietary or accessibility restrictions:

_____

_____

For questions contact: Jeunice Salita-Lim
Program Planner
7100 Connecticut Avenue
Chevy Chase, MD 20815
301-961-2892
jsalita@fourhcouncil.edu