

**4-H Participant Information/Enrollment Form** (NOT FOR RESIDENTIAL CAMP)

Note: The form must be completed by the participant and/or parent or guardian in order to participate in the 4-H program. **All items must be completed, even if the response is not applicable – indicate by using N/A (i.e. no health insurance).** Failure to complete this form in its entirety will result in the person being ineligible to participate in 4-H activities. Please print in blue or black ink to allow for photocopying.

Name: \_\_\_\_\_ County/Area: \_\_\_\_\_  
 Preferred Name: \_\_\_\_\_ School Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Grade: \_\_\_\_\_  
 4-Her Phone: \_\_\_\_\_ 4-H Year: \_\_\_\_\_ Gender: Female Male  
 4-Her Email: \_\_\_\_\_  
 Residence:  
 Farm  Town < 10,000 or Rural Non-Farm  Town/City/Suburb 10,000-50,000  City/Suburb >50,000  City– Central >50,000  
 Race (please choose more than one if applicable):  American Indian  Asian  Black  Native Hawaiian or Pacific Islander  
 White  Prefer Not to Say Not Listed: \_\_\_\_\_  
 Ethnicity: Hispanic Non-Hispanic T-Shirt Size: \_\_\_\_\_

Parent/Guardian 1: \_\_\_\_\_ Phone number: \_\_\_\_\_  
 Email: \_\_\_\_\_ Emergency Contact? Yes No  
 Parent/Guardian 2: \_\_\_\_\_ Phone number: \_\_\_\_\_  
 Email: \_\_\_\_\_ Emergency Contact? Yes No

Is any member of your family a current or former member of the United States Military or National Guard? Yes No

**Health History**

Does the participant have, or at any time has had, any of the following? Check “Yes” or “No” to each item. Please explain any “yes” answers (noting the number of the item) in the space below or on an additional sheet if necessary. Reporting conditions will not prevent a person from attending and will be kept confidential.

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1) Asthma .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Bronchitis.....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Convulsions.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Diabetes.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Ear Infection.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Fainting.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Heart Condition.....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Headaches.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Hypoglycemia.....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Serious Allergy to Insects.....      | <input type="checkbox"/> | <input type="checkbox"/> |
| 11) Serious Allergy to Nuts.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| 12) Serious Allergy to Gluten.....       | <input type="checkbox"/> | <input type="checkbox"/> |
| 13) Serious Allergy to Dairy.....        | <input type="checkbox"/> | <input type="checkbox"/> |
| 14) Wear Glasses/Contacts.....           | <input type="checkbox"/> | <input type="checkbox"/> |
| 15) Other Conditions.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| 16) Other Allergy (please explain) ..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain any “yes” responses, including medications taken for any conditions:

---

Please explain any restrictions (dietary, physical, etc):

---

Social, emotional, and/or behavioral health information:

The following over the counter medications may be administered to my child without contacting me:

- Antihistamine Pill  Antacid  Ibuprofen (Advil)  Hydrocortisone Cream  
 Acetaminophen (Tylenol)  Decongestant  Dramamine  Polysporin (topical antibiotic)

**Medical Treatment**

All information provided on this form is correct and complete to the best of my knowledge. This person has permission to engage in all events and activities. I hereby give permission to the event designee to provide routine health care, administer prescription and over the counter medications as noted and seek emergency medical treatment if warranted. I agree to the release of all records necessary for medical treatment, billing, or insurance. In the event I cannot be reached in an emergency, I give permission to the attending physician to secure and administer treatment, including hospitalization.

**SIGNATURE OF PARENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Publicity Release**

I hereby grant the 4-H program, University of Kentucky and their agents, the right to use, reproduce, assign and/or distribute still pictures, video and sound recordings of myself or my minor child without compensation for use in promotion, advertising, educational publications or online content.

**SIGNATURE OF /GUARDIAN:** \_\_\_\_\_  **NO, I do not permit**

