

Name \_\_\_\_\_

County \_\_\_\_\_

## HEALTH HISTORY FOR VOLUNTEER OR PAID STAFF MEMBERS

The purpose of this form is to provide pertinent information concerning your health. Each section should be completed in full. If under 18, a parent or guardian must sign section IV.

### I. IDENTIFICATION

Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
(Last) (First) (M.)

Social Security Number \_\_\_/\_\_\_/\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Sex ( ) Male ( ) Female

Parents/Guardian or Spouse \_\_\_\_\_

Home Address \_\_\_\_\_  
(Street/PO Box) (City) (State) (Zip)

Daytime Phone (\_\_\_\_) \_\_\_\_\_ Nighttime Phone (\_\_\_\_) \_\_\_\_\_

Work Place Address \_\_\_\_\_  
(Street/PO Box) (City) (State) (Zip)

Work Phone (\_\_\_\_) \_\_\_\_\_

Other Emergency Contact (if appropriate) \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address) (Phone)

### PUBLICITY RELEASE

**Also, as indicated by the signature below, I authorize the University of Tennessee to photograph, film, audio/video, record and/or televise my image and voice, and biographical material, in whole or in part in any medium now known or developed in the future, without any restrictions.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Date received in 4-H Center or county office \_\_\_\_\_

F600B-2.5M-3/99 (Rev) E12-2015-00-024099

*A state partner in the Cooperative Extension System*

The Agricultural Extension Service offers its programs to all eligible persons regardless of race, color

Age, national origin, sex or disability and is an Equal Opportunity Employer

Cooperative Extension Work in Agriculture and Home Economics

The University of Tennessee Institute of Agriculture, U.S. Department of Agriculture, and

County governments cooperating in the furtherance of Acts of May 8 and June 30, 1914

Agricultural Extension Services

Billy G. Hicks, Dean

## PERSONAL HEALTH AND MEDICAL RECORD

Name of Family Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Family Medical/ Hospital insurance: \_\_\_\_\_  
(Carrier) (Policy or Group Number)

### II MEDICAL INFORMATION (check all that apply)

Allergy to a medicine, food, plant, or insect toxin. Explain \_\_\_\_\_

Any condition that may require special care, diet or restriction of activities for medical reasons. Explain \_\_\_\_\_

Asthma  Heart Trouble  Nose Bleeds  Diabetes  Convulsions  Fainting Spells

Do you wear:  Dentures  Contact Lens  Other explain \_\_\_\_\_

Are you allergic to the following:  Penicillin  Sulfa Drugs  Tetracycline  Aspirin

List other drugs or allergens: \_\_\_\_\_

Is any medication, including medication for behavior modification, being taken at the present time?  Yes  No

If yes, explain \_\_\_\_\_

### III MEDICAL HISTORY

Date of most recent examination \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you aware of any current health problems?  Yes  No . If yes explain. \_\_\_\_\_

Is there any disease, accident, illness or past/present history related to the following: If yes, please give dates and full details.

	No	Yes	Year		No	Yes	Year
Serious illness/injury	___	___	_____	Appendicitis	___	___	_____
Surgery	___	___	_____	Kidney infection	___	___	_____
Ears, Eyes	___	___	_____	Back, Limb, Joints	___	___	_____
Teeth, Tonsils	___	___	_____	Blood	___	___	_____
Rheumatic Fever	___	___	_____	Stomach	___	___	_____

\*\*\*\*\*

<u>Immunizations</u>	<u>Last Yr. Given</u>	<u>Immunizations</u>	<u>Last Year Given</u>	<u>Has Had</u>
Tetanus	_____	Measles	_____	Measles _____
Diphtheria	_____	Mumps	_____	Mumps _____
Polio	_____	Rubella	_____	Rubella _____
Hepatitis A, B or C <small>(circle one/any)</small>	_____	Variceilla (chicken pox)	_____	Chicken Pox _____
				Tuberculosis _____

### IV EMERGENCY MEDICAL APPROVAL (by Parent or Guardian)

In consideration of \_\_\_\_\_'s (name) participation in the 4-H event or activity. I provide the following release. I understand that a health problem or a medical emergency may develop that necessitates the administration of medical care, hospitalization or surgery. In the event of illness or injury to \_\_\_\_\_ (name), I hereby authorize the University of Tennessee and its representative(s) or agent(s) to provide the medical history form to healthcare personnel. I authorize any physician, healthcare provider or any hospital to provide reasonable and necessary medical treatment or supplies. This original permission or a photostatic copy thereof is equally valid as an authorization.

I recognize that the University of Tennessee's sickness and accident insurance does not provide full coverage for participants in this activity or event. I accept responsibility for payments of those medical costs incurred for injuries or illnesses which are not covered by the University of Tennessee's insurance.

I have read this Release and Assumption of Risk Agreement and signed it on behalf of myself, my heirs, assigns, and anyone entitled to act upon my behalf.

\*Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian) (Month Day Year)

\* If for any religious reasons you cannot sign this, your Extension office should be contacted for a legal waiver which must be signed for attendance