

California 4-H Youth Development Program
Health History Information
 University of California Cooperative Extension

First Name _____	Last Name _____	Date of Birth _____/_____/_____	Social Security Number _____
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Subject to:	Yes	No	Now Have or Have Had	Yes	No
Colds			Heart Trouble		
Sore Throat			Asthma		
Fainting Spells			Lung Trouble		
Bronchitis			Sinus Trouble		
Convulsions			Hernia (rupture)		
Cramps			Appendicitis		
Allergies			Has appendix been removed?		
Wear corrective lenses?			Do you walk in your sleep?		
Is hearing good?					
Currently under any type of medical care?					
Is there history of behavior disorders, emotional disturbances, or severe moodiness?					
Been under psychiatric treatment within the past five years?					

Date of last Tetanus Vaccination: _____

Please check over-the-counter medications that may be administered:

- Tylenol
 Ibuprofen
 Cough Syrup
 Decongestant
 Dramamine
 Antacid
 Polysporin
 Hydrocortisone
 Other: _____

Please identify allergies including allergies to food, medications, and drug reactions:

Please list any disabilities or disorders that may affect participation at 4-H events such as:
 eyesight, hearing, speech, paralysis, diabetes, ulcer, etc.

Please list all current medications:

Name of Medication	Dosage	Times Taken

Remarks and special instructions. Please explain "yes" answers on this page.

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