2020-2021 Louisiana 4-H Youth Development Program

LOUISIANA 4-H MEDICAL/HEALTH FORM

IMPORTANT - PLEASE READ!

To All 4-H Families:

It is one of the highest priorities that 4-H protects and cares for our 4-H members and adults who are participating in 4-H events, activities, workshops, and trips. To make this possible, we need your help by completing with the utmost correct and current information, and maintaining the information on an annual 4-H Medical/Health Form.

Louisiana 4-H realizes the attached form is a little lengthy, but your safety and health is worth it to us! In order to make it easier, 4-H families do have the option of completing the form only once a year and then providing an "*Certification of Current and Correct Information*" form any time the form is needed throughout the current 4-H year for a 4-H event, activity, or trip. However, if anything changes related to the health, well-being, or medication of the person named on the form, a new complete form is required. This ensures that the Louisiana 4-H and Youth Development Program has clear and precise medical directives during an emergency.

Because the 4-H Program is allowing families to provide a Certificate of Current and Correct Information form, it is imperative that each family ***turn one copy into their Parish 4-H Office and retain a copy of this Medical/Health Form for your records and reference***. For ease and to save on paper, you will only have to provide the certification form each time to the Parish 4-H Office.

Thank you for being our partner in protecting our youth and adults in Louisiana 4-H.

Sincerely,
Toby L. Lepley, Ph.D.
Associate Vice-President, 4-H Program Leader

CONFIDENTIALITY POLICY

Respecting the privacy of our members, parents, volunteers, staff, and of Louisiana 4-H itself is a basic value. Personal information is confidential and should not be disclosed or discussed with anyone without permission or authorization from the individual and/or parent/guardian listed on this form unless the individual is involved in the care and supervision of the minor. Care shall also be taken to ensure that unauthorized individuals do not overhear any discussion of confidential information and that documents containing confidential information are not left in the open or inadvertently shared.

Employees and volunteers of LSU AgCenter may be exposed to information which is confidential and/or privileged and proprietary in nature. It is the policy of LSU AgCenter that such information must be kept confidential both during and after employment or volunteer service. Staff and volunteers, including board members, are expected to return materials containing privileged or confidential information at the time of separation from employment of expiration of service.

INSTRUCTIONS TO LCES AGENTS AND SUPPORT STAFF:

1. If any change occurs a **NEW** Medical/Health Form must be completed. **NO EDITS OR CHANGES ARE ALLOWED TO A MEDICAL/HEALTH FORM. All medical forms (current and non-current) must be retained in the parish office.**
2. As Certificates of Current and Correct Information forms are received, they must be secured to the back of the medical/health form.
3. For in-parish events, the original forms may be taken to the event as needed. For regional and/or state events, it is advised the parish office make the necessary copy of the medical/health form and the certificate of current and correct information and send in a closed envelope with the agent and/or supervising chaperone.
4. All medical/health forms when not in use for an event, activity, or trip must reside in the parish office in a secure location and inaccessible to the general public.
5. Forms are NOT to be accepted via email, fax, or other electronically transmitted format. The Medical/Health form cannot be saved on any electronic device owned or manged by the LSU AgCenter.

Last Revision: 5/2020

2020-2021 Louisiana 4-H Youth Development Program

LOUISIANA 4-H MEDICAL/HEALTH FORM

(To be completed and signed prior to event. Participant MAY NOT participate without a health form.)

Event or Activity* _____

** The Louisiana 4-H Program will allow 4-H families to complete one medical/health form per year as long as ABSOLUTELY NO information changes on the form. If you wish to exercise this option, you may leave the event or activity line blank. IF ANY INFORMATION CHANGES A NEW FORM MUST BE COMPLETED - NO EXCEPTIONS!!!*

PARTICIPANT INFORMATION

Name of Participant _____ Date of Birth _____

First Middle Last Month/Day/Year

Address _____

Street/PO Box City State Zip Code

Cell Phone _____ Parish _____

PARENT/GUARDIAN'S INFORMATION FOR YOUTH

Parent/Guardian's Name _____

Phone Cell _____ Work _____ Home _____

Family Physician _____ Office Phone _____

Alternate Phone _____

Insurance
(Complete for Adults & Youth)

Company Name _____

Company Address _____

Name of Insured _____

Group Number _____ Policy Number _____

EMERGENCY CONTACTS

	1st Emergency Contact	2nd Emergency Contact	3rd Emergency Contact
Name			
Relationship			
Home Phone			
Cell Phone			
Work Phone			
Email			

PARTICIPANT PICK UP (YOUTH ONLY)

Please list below individuals who are authorized to pick up or leave with your child. A photo I.D. may be required for these individuals to pick up or leave with your child. If additional pickups are needed please add a separate sheet containing the information below and attach it to this form.

	PERSON #1	PERSON #2
Name		
Relationship		
Cell Phone		
Driver's License #		

Youth will not be allowed to leave with anyone not authorized. Youth will not be released to individuals without permission from the parent or legal guardian. If based on the opinion of staff, the individual appears to be impaired, the child will not be released.

Please list any custody information we should be aware of on a separate sheet and attach it to this form.

LSU AgCenter
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PARTICIPANT HEALTH AND MEDICAL HISTORY

SECTION 1: GENERAL HEALTH. Is there past or present history of the following? Please indicate **YES** or **NO** on each.

	YES	No
Appendicitis		
Allergies/sinus problems		
Asthma/persistent cough		
Bedwetting		
Bleeding disorder		
Convulsions/fainting		
Diabetes/hypoglycemia		
Eye/ear problems		
Frequent ear infections		
Gall bladder problems		
Head Injury/Concussion		
Hernia		
Hypertension		
Infectious disease		
Insect Bites*		
Joint/back or limb pain		
Arthritis or other conditions		
Kidney or liver disease		
Menstrual problems		
Nervous condition/depression		
Nose problems		
Physical disability		
Recent surgery/injury		
Serious illness		
Serious injury		
Skin/gland problems		
Sleepwalking		
Stomach/bowel problems		
Tuberculosis		
Ulcers (stomach/intestines)		
Urinary problems		
Wears Contacts		

**Localized redness/swelling do not constitute insect allergy. Body-wide rash, swelling, and difficulty breathing do constitute insect allergy (anaphylaxis).*

Explain any "Yes" items and list any other problems, including the diagnosis, date of injury or illness, hospital, length of hospitalization, name of doctor, etc. List any exposure to infectious disease in the two weeks prior to event.

(Attach a page if extra space is needed for explanation)

SECTION 2: MENTAL, EMOTIONAL AND SOCIAL HEALTH
Please indicate **YES** or **NO** on each.

Has the participant:		YES	NO
1	Ever been treated for attention deficit disorder (ADD) or attention deficit/ hyperactivity disorder (ADHD)?		
2	Ever been treated for emotional or behavioral difficulties or an eating disorder?		
3	In the past 12 months, seen a professional to address mental/emotional health concerns?		
4	Had a significant life event that continues to affect the participants life? *(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc)*		
5	Ever been away from home/family for an overnight event?		

Explain any "Yes" items noting the number of the question. Please include any ways we can provide support and/or encouragement to assist them while participating.

(Attach a page if extra space is needed for explanation)

ATTENTION: BY LAW, IF CHILD/MINOR ABUSE IS LISTED/MENTIONED, THE LSU AGCENTER IS MANADATED TO REPORT TO DEPARTMENT OF CHILDREN AND FAMILY SERVICES.

SECTION 3: ALLERGIES

- ☐ **NO** known allergies
- ☐ **ALLERGIC** to:
  - ☐ Foods
  - ☐ Medicines
  - ☐ Environment
  - ☐ Other: _____

What is participant allergic to? (Specific)	What is the typical reaction seen?	What is treatment needed?

(Attach a page if extra space is needed for explanation)

SECTION 4: DIET/NUTRITION

- ☐ Eats regular diet
- ☐ Eats regular vegetarian diet
- ☐ Lactose intolerant
- ☐ Glucose intolerant
- ☐ Gluten intolerant
- ☐ Other, please explain below.

Information provided here does not guarantee the 4-H Program will provide special meals or needs.

Dietary modifications require a physician's written instructions to be given to 4-H staff two (2) weeks prior to the event.

Dietary request will not be honored for food preferences, personal taste, or for "picky eaters".

Explain any dietary needs noted above.

(Attach a page if extra space is needed for explanation)

PARTICIPANT HEALTH AND MEDICAL HISTORY

SECTION 5: OVER-THE-COUNTER (OTC) MEDICATION.

At times OTC medication(s) need to be administered, if approval is indicated by the 4-H member's parent or guardian. Please complete the following section if your child may need any of these OTC medications during his/her stay. **NOTE:** Unless we have parental authorization, we cannot administer ANY medications.

	YES	No
Acetaminophen (i.e. Tylenol)		
Ibuprofen (i.e. Motrin, Advil)		
Naproxen/NSAID (i.e. Aleve)		
Pepto-Bismol, Milk of Magnesia or Mylanta (for upset stomach/diarrhea)		
Immodium or Kaopectate (for diarrhea)		
Laxative (for constipation – i.e. Ex-Lax)		
Antihistamine/allergy medicine		
Pseudoephedrine decongestant (i.e. Sudafed)		
Guaifenesin cough syrup (i.e. Robitussin)		
Sore throat spray/lozenges		
Diphenhydramine antihistamine/allergy medicine (i.e. Benadryl)		
Aspirin		
Cough drops		
Antibiotic cream		
Insect repellent/Bug Spray		
Aloe gel or cream (for sunburn)		
Calamine Lotion		
Sunscreen		
Visine/eye drops (minor eye irritation)		
Micatin or anti-fungus treatment as directed for athlete's foot.		
Rolaids or Tums for acid reflux, heartburn or indigestion as directed.		
Medicated lip ointment for dry, chapped lips, lip blisters or canker sores as directed.		
Swimmer's ear drops		
Other (list any other approved over-the-counter drugs):		

OVER-THE-COUNTER MEDICATION NOTE(S):

- **Staff reserves the right to use generic equivalents when available for the name brand over-the-counter medications listed above.**
- **O-T-C Medication may or may not be available at all 4-H events based on location, length of event, and/or other rules/guidelines.**

SECTION 6: SPECIAL OR PRESCRIPTION MEDICATION

☐ **NO** this participant does not need to take any special or prescription medication while at this event/program.

☐ **YES** this participant will need to take special or prescription medication while at this event.

If YES, you must complete PAGE 4 in detail.

SECTION 7: IMMUNIZATION DATES *(must be current)*

IMMUNIZATION	DATE
Tetanus (DTaP/DTP/Td)	
Hepatitis B (Hep B - 3 Dose)	

In pursuant with the rules set forth by Louisiana law (Louisiana Revised Statutes 17:170 Sec E) to the Louisiana Department of Eduction, the Louisiana 4-H Youth Development Program will use LDE's exemption process (with modifications) from immunizations for all 4-H members/volunteers attending 4-H functions where immunization records are required.

Although Louisiana has vaccination requirements for children entering daycare or school, these requirements can be waived. The child's parent or guardian may request an exemption in writing for medical or religious/ philosophical reasons. The parent or guardian simply provides their child's name, date of birth and states their decision to exempt their child from the school vaccination requirements, and files this with the 4-H Agent, Camp Director, or 4-H Event Manager. ***Medical exemptions are completed by the child's healthcare provider.***

Those requesting an exemption must complete the Louisiana 4-H Form entitled: "Statement of Exemption from Immunization"

SECTION 8: CERTIFICATION OF HEALTH/MEDICAL RECORD

To my knowledge, this participant, has no health problems, unless stated earlier, and can SAFELY PARTICIPATE in this event.

FURTHERMORE, I, the undersigned, certify the participant for which is form is completed for has had no contagious or communicable disease and/or illness within the last 30 days that would preclude them from participating in this event/program. If any health problems or illnesses have occurred, they are explained in this form.

I understand that such administration of O-T-C's will be not done under the supervision of medical personnel. I also agree that any first aid treatment may be given as needed. Any condition which is associated with fever, significant inflammation and/or did not respond to the above outlined treatment, would be followed-up with a consultation with the camper's parents. Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I understand that these over-the-counter medications are not necessarily kept on hand and available to be administered immediately.

I authorize the administration of over-the-counter medications to my child as indicated above. I shall indemnify and hold harmless the LSU AgCenter, its staff, and volunteers. LSU AgCenter's, its Board of Supervisors, Administration, Faculty, Staff, Volunteers, and all other officers, directors, employees and agents against any claims that may arise relating to my child being administered the above indicated over-the-counter medications.

I/We have legal authority to consent to medical treatment for the camper named above, including the administration of medication at the above referenced Camp.

Signature of Parent/Guardian(s) or Adult _____ Date _____

Primary Phone Number (Cell/Home) _____ Work Phone Number _____

WHAT HAVE WE FORGOTTEN TO ASK?

Please attach an additional page with any information about the participant that you think is important or that may affect the participant's ability to fully participate.

2020-2021 Louisiana 4-H Youth Development Program

PARENT/GUARDIAN AUTHORIZATION AND CONSENT FOR SPECIAL AND/OR PRESCRIPTION MEDICATION

TO: Louisiana 4-H Youth Development Program and/or representative

Please administer my child: _____ (Child's name) the medication(s) listed below as order by

Dr. _____ (Name of Physician) _____ (Phone)

I accept the rules of the Louisiana 4-H Youth Development concerning the giving of medication, including the following:

1. The Camp Nurse (4-H Camp), or authorized 4-H personnel, will administer medication.
2. All medication is given to the 4-H personnel by a parent or guardian before departure for an event.
3. All prescription medication is to be prescribed by a physician.
4. All prescription medication must be in the original container with a label from the pharmacy showing the name of the medication, dosage, date last filled (must not be expired or expire during the 4-H event), child's name, and how often to administer the medication.
5. All medication (prescription and over the counter) must be in its original container and put inside a Ziploc bag with the child's name and parish written on the outside of the bag.
6. Over the counter medication must be unopened and in the original package when given to the parish 4-H agent. All over the counter medication will be administered according to the directions on the package, unless a signed physician's note indicates otherwise.
7. We require that you send only the amount of medication needed for the duration of the 4-H event **(NO "extras")**

NAME OF MEDICATION (Brand or Generic Name)	DATE STARTED	REASON FOR TAKING IT	ESTIMATED TIME GIVEN/TAKEN	AMOUNT OR DOSE TO BE GIVEN	HOW IS IT GIVEN/TAKEN
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:_____		

If additional medications are needed, please complete a second form listing those medications.

I certify to the Louisiana Cooperative Extension Service and the 4-H Youth Development Program that it is necessary for my child to receive the above listed medication(s) during this 4-H activity/trip/experience.

_____ _____

Signature of Parent(s) or Guardian(s) Date

_____

Parent(s) or Guardian(s) Address, City, State, and Zip

_____ _____

Primary Phone Number (Cell/Home) Work Phone Number