TEXAS 4-H YOUTH DEVELOPMENT FORM
HSS - HEALTH AND SAFETY STATEMENT
2025-2026

TEXAS A&M AGRILIFE EXTENSION

Revised: 6/2025

Check One: ☐ Youth ☐ Adult County: _____ District: _____

Event: _____ Event Dates: _____

Section I. Participant Information

First Name: _____ Gender: ☐ Female ☐ Male

Last Name: _____ Date of Birth: ___/___/___ Age: _____

Address: _____ Name of Physician: _____

City, State, Zip: _____ Physician's Number: _____

Phone Number: ( ) - _____ Date of last physical exam: _____

Section II. Emergency Contact Information

Contact Name #1: _____ Relationship: _____ Contact Name #1: _____ Relationship: _____

Phone Numbers: ( ) - _____ ( ) - _____ Phone Numbers: ( ) - _____ ( ) - _____

Address: _____ Address: _____

Section III. Health History (Check the appropriate answer; if YES, use space to the right to provide additional information)

Have you had any operations or injuries that impede participation?	☐ No	☐ Yes	_____
Are there any activities to be limited/discouraged by a physician's advice?	☐ No	☐ Yes	_____
Have you had or do you currently have any heart problems?	☐ No	☐ Yes	_____
Do you require any accommodation to participate in scheduled activities?	☐ No	☐ Yes	_____
Do you have any chronic recurring illness or communicable diseases?	☐ No	☐ Yes	_____
Are you allergic to any medications, food or food ingredients, insects, or pollens?	☐ No	☐ Yes	_____
Do you require an inhaler, epinephrine injector, or other item that you keep at all times?	☐ No	☐ Yes	_____
Do you have a medically prescribed meal plan or dietary restrictions?	☐ No	☐ Yes	_____
Do you have Epilepsy?	☐ No	☐ Yes	_____
Do you have Diabetes?	☐ No	☐ Yes	_____
List any other health related information:	☐ No	☐ Yes	_____

Section IV: Medications (ALL medications must be in ORIGINAL container with ORIGINAL LABEL.)

Are there prescribed or over-the-counter medications currently being taken? ☐ No ☐ Yes

If yes, please describe: _____

Section V. Insurance Information – Please provide a copy of your insurance card.

Do you carry family medical/hospital insurance? ☐ No ☐ Yes

Carrier: _____ Policy: _____

Section VI. Release of Participant (If minor) at conclusion of activity/camp/event/program

I/We do hereby authorize release of said minor child to the following person/people: (please list all persons, including parents)

_____

Further, I/We require that said minor child NOT be released to the following person/people:

_____

Section VII. Health and Safety Statement Certification

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand this information is confidential and is to be used only by AgriLife Extension Staff or designated Volunteers for health and safety reasons. I hereby consent to the use of this information for such purposes.

Participant Certification	**Parent/Guardian Certification** (only if participant is under the age of 18)
Printed Name: _____	Printed Name: _____
Signature: _____	Signature: _____
Date: _____	Date: _____

Programs with multiple dates/sessions. I certify this information is correct. Date: _____ Initial: _____ Date: _____ Initial: _____