



**University of California Division of Agriculture and Natural Resources  
4-H Youth Development Program  
Health History Information**

_____	_____	_____	____/____/____
First Name	Last Name	County	Date of Birth

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?					

Date of last Tetanus Vaccination: \_\_\_\_\_

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

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Please list any disability accommodations you will need in order to participate in this program or activity.

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Please list all current medications:

Name of Medication	Dosage	Times Taken

Please include any additional remarks and special instructions to better assist emergency service personnel.

Please explain "yes" answers on this page.

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