

Bridle Bunch Horse & Pony Activity Health Form  
(Youth)

\_\_\_\_\_  
Name Birthdate

\_\_\_\_\_  
Street Address City State ZIP code

( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Day Phone Number Evening Phone Number

List any activities the participant should avoid (i.e., swimming):

Physical Record of Participant	Yes	No
Heart Condition	_____	_____
Diabetes	_____	_____
Ear Infections	_____	_____
Bedwetting	_____	_____
Allergy to any medication	_____	_____

List medicines allergic to: \_\_\_\_\_

List other allergies \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Please list any current medication being taken on reverse side of this form.

Any other medical record information that would be beneficial during the program or in an emergency:

Complete this portion if the student is taking prescription medications at the time of the event or if over-the-counter medication is to be administered by an Extension staff member or other authorized personnel. Medications must be carried in their original containers.

Name of Medication: \_\_\_\_\_

What Illness/Condition is this medication intended for: \_\_\_\_\_

Check one of the following:

\_\_\_\_ Tylenol/Ibuprofen may be administered by 4-H Youth Development event personnel

\_\_\_\_ Benadryl may be administered by 4-H Youth Development event personnel

\_\_\_\_ Medication is to be self administered by student

\_\_\_\_ Medication is to be administered by 4-H Youth Development event personnel

Dosage: \_\_\_\_\_ Refrigeration? Yes \_\_\_\_ No \_\_\_\_

Special Instructions: \_\_\_\_\_

PARENTAL AUTHORIZATION

Pursuant to Indiana Code Paragraph 16-36-1-6 and subject to any limitations listed below, I request and authorize Purdue University Cooperative Extension Service employees and their authorized agents to arrange for all reasonably necessary medical care, including transportation and hospitalization, for my child while in attendance at and participating in 4-H Youth Development events and activities. I also understand that, as a result of my child's participation in this program, it will be necessary for Purdue CES employees and other authorized personnel with the program to have access to relevant medical information pertaining to my child, and I authorize the use and disclosure of my child's medical information to promote a safe and healthy experience for my child.

\_\_\_\_\_  
Parent/Legal Guardian Signature Date

Parent/Guardian Telephone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Day Evening

In case we cannot reach you, please list the name and phone number of a second party to contact:

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Day Evening