



**ALERT, EVACUATE AND SHELTER PROJECT
HEALTH INFORMATION and CONSENT for EMERGENCY TREATMENT**

State (Territory) Delegation:		
First Name:	Last Name:	
Street Address:		
City:	State:	Zip:
Home Phone: ()	Birth Date:	Sex: Male Female
Insurance Provider (optional):	Policy Number (optional):	
Family Physician or Health center (optional):	Physician Phone (optional): ()	
Date of Last Tetanus Shot:		
CONDITION	YES	NO
1. Respiratory problems: (asthma, persistent cough, abnormal chest x-ray, T.B., etc.)		
2. Heart disease (high/low blood pressure, murmurs, chest pain, rheumatic fever, etc.)		
3. Stomach or Intestinal Problems (ulcers, jaundice, hernia, colitis, indigestion, etc.)		
4. Kidney, Gall Bladder, or Liver Disease		
5. Diabetes or Hypoglycemia (low blood sugar)		
6. Muscular/Skeletal Problems (arthritis, hernia, recent fractures, etc.)		
7. Eye, Ear, Nose or Throat problems (hay fever, ear infection, impaired sight or hearing)		
8. Skin diseases		
9. Nervous Disorders (convulsions, epilepsy, dizziness, loss of consciousness, etc.)		
10. Emotional or Mental Disorders (frequent anxiety, excessive fears, excessive crying, etc.)		
11. Surgical operations, accidents, or injuries in the past 2 years		
12. Recent Exposure to Contagious Disease (within the past year)		
13. Are you currently under a doctor's care for chronic or recurring problem?		
14. Are you currently taking prescription medications? If yes, please list:		
15. Allergies to Medicines (penicillin, tetanus, etc.). If yes, please list:		
16. Allergies to Food (peanuts, wheat, gluten, etc.). If yes, please list:		
17. Do you have any limiting physical conditions? If yes, list any special assistance needs:		

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Delegate Name: _____

Emergency Contact #1:		
Name: _____		Relationship: _____
Address: _____		
City: _____	State: _____	Zip: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____

Emergency Contact #2:		
Name: _____		Relationship: _____
Address: _____		
City: _____	State: _____	Zip: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____

In case of emergency, I hereby authorize designated representatives of the Alert, Evacuate and Shelter training conference to consent on my behalf to medical treatment and/or hospital care as advised and deemed necessary by emergency medical staff, physicians or surgeons. I also understand that all financial obligations incurred, if not covered by insurance, will be my responsibility.

Additionally, I have also read and noted that in case of emergency while attending the Alert, Evacuate and Shelter training conference, delegates may be contacted as follows:

Carol Benesh
University of Nevada Cooperative Extension
Nevada State 4-H Program Office
M/S/405 1305 Evans Avenue
Reno, Nevada 89557
775-784-4378

Finally, I understand that a variety of activities are scheduled as part of the Alert, Evacuate and Shelter training conference, including travel by motor vehicle to and from activities, recreational activities, and off-site educational activities.

I hereby attest and verify that I have been informed of potential activities and agree that this participant can safely attend the Alert, Evacuate and Shelter training conference.

Delegate Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Name (please print): _____

Notary Public (optional for minors)	
Name: _____	
State of: _____	County of: _____
Sworn to and subscribed to before me this ____ day of _____, 200__.	
My commission expires on this date: _____	