COMPLETION OF THIS TWO PAGE FORM IS REQUIRED

_____ _____ _____/_____/_____

Name of Youth Member | County of Enrollment | Date of Birth

1. Please check the following conditions that apply to your child:

- ☐ ADD/ADHD
- ☐ Appendicitis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Convulsions/seizures
- ☐ Diabetes
- ☐ Fainting Spells
- ☐ Heart or cardio-vascular problems/disease
- ☐ Migraine headaches
- ☐ Anxiety

List other conditions:

2. Please list all medications taken within the last six months:

Name of Medication	Purpose	Dosage	Times Taken	Can the child self-medicate? Yes or No

3. Please identify allergies:

Does the youth carry an Epipen?	
Drug reactions/Medications	
Foods; peanuts, dairy, gluten	
Insect bites/Stings	
Other	

4. Please check over-the counter medications that can be administered by 4-H staff and volunteers:

- ☐ Antacid
- ☐ Cough Syrup
- ☐ Decongestant
- ☐ Dramamine
- ☐ Hydrocortisone
- ☐ Ibuprofen
- ☐ Polysporin
- ☐ Tylenol
- ☐ Benadryl
- ☐ Other: _____ _____

5. Are there any operations or serious illnesses within the last year AND any complications that we should be aware of?

_____

_____

6. Provide any additional information not covered above that a physician, emergency personnel or staff would find helpful:

_____

_____

7. <u>If you have any question about your child's health</u>, please secure a complete health examination from a physician and provide a signed physician's statement permitting participation.

This Medical Release Form is authorized for all 4-H Youth Development meetings & activities for the current 4-H year:

_____ Name of Member

_____ Name of 4-H Club(s)/Group(s)

While my child is attending or traveling to or from a 4-H function, I HEREBY AUTHORIZE THE ADULT 4-H VOLUNTEER LEADER OR 4-H STAFF MEMBER, or in his/her absence or disability, any adult accompanying or assisting him/her, TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR SAID MINOR:

- Any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act; or any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practices Act.
- This authorization shall remain effective until my child completes his/her activities in this program unless sooner revoked in writing. I understand that as a parent/guardian, I will be responsible for the cost of any service or treatment provided not covered by the American Income Life Accident Policy purchased for enrolled 4-H members.

EMERGENCY CONTACT INFORMATION

_____

Name | Relationship to Youth Identified Above

(_____)_____ (_____)_____

Home Phone (with area code) | Cell Phone (with area code)

_____

Street Address | City | State | Zip

_____

Person to Contact if Parent/Guardian Cannot Be Reached | Cell Phone | Relationship to Child

_____

Name of Child's Physician (optional) | Phone number

AUTHORIZATION, CONSENT AND RELEASE

I hereby certify that my child is in good health and can participate in and travel to all functions of the 4-H Youth Development Program.

- I understand is it my responsibility to keep the Health History Information form updated regarding my child/ward's medical situation including pre-existing conditions, allergies, change in medications or medical status so that in case of a medical emergency appropriate medical assistance can be given, and may affect the youth's regular participation in program activities.
- I understand that the volunteer leader(s) and 4-H staff understand that medical information is confidential and will release health information only to designated medical personnel in the event of an emergency, as authorized by my signature below.
- I understand that 4-H may require a doctor's note if there are any questions about the ability of the member to participate safely in 4-H activities.
- I certify that I have accurately provided the required information, and signed the **Permission & Liability Waiver** form.
- In case of emergency, I give my consent for necessary examination and treatment as prescribed by the attending physician.

_____ _____

Signature of Custodial Parent(s)/Guardian | Date