Print Form

Medical Release Form for 4-H Youth & Adults

Participant Information:

Name: _____ County: _____

Address: _____

Name of Parent or Legal Guardian: (YOUTH ONLY) _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

In Case of Emergency

Primary Contact: _____ Phone: _____

City: _____ State: _____

Alternate Contact: _____ Phone: _____

City: _____ State: _____

Insurance Information

Name of Insurance Carrier: _____

Policy Holder Name: _____ Policy #: _____

Date of Last:

Tetanus Shot: _____ Polio Shot: _____ Mumps Shot: _____

Measles Shot: _____ Rubella Shot: _____

Medical Information: (check all that apply and explain if necessary)

☐ Stomach or Intestinal problems _____

☐ Diabetes or hypogycemia (low blood sugar) _____

☐ Nervous disorder (convulsions, epilepsy, dizziness, ect.) _____

☐ Respiratory problems _____

☐ Heart Disease _____

☐ Any allergies to medication _____

☐ Any allergies to food or plants _____

☐ Special diet or food restrictions _____

☐ Are you currently under a doctor's care? _____

_____

☐ Are you currently taking medications? _____

_____

☐ Are there any physical restrictions or medical problems that may require special considerations? _____

_____

Authorization for Treatment (YOUTH ONLY)

I, _____ do herby give permission to _____
Parent or Guardian NAME *Chaperone NAME*

to seek and obtain any medical care necessary for my child _____
Youth Participant NAME

Parent/Guardian Signature _____ Date _____

All Participants

To the Best of my knowledge, accurate information has been provided in all areas of this form.

Adult Participant Signature _____ Date _____

OR

Youth Participant Signature _____ Date _____

Parent/Guardian Signature _____ Date _____