THE UNIVERSITY OF ARIZONA
Cooperative Extension

ARIZONA 4-H YOUTH DEVELOPMENT

PARENTAL/GUARDIAN CONSENT & RELEASE OF MEDICAL INFORMATION

Participants Name: _____

Birth Date: _____ E-mail: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Do you have a disability for which you seek an accommodation? If so, please list your needs:

_____

Emergency Medical Information:

For treatment purposes:

_____

Name of Physician / Licensed Medical Practitioner — Phone Number

_____

Insurance Company — Policy Number

_____

List Prescribed Medication

_____

List approved "Non-Prescription" Medications your child may be given (aspirin, ibuprofen, cold remedies, etc)

_____

List activities prohibited due to medical conditions

_____

List allergies (food, drug, plant, insect, etc.)

Immunization dates (Month/Year): Tetanus: _____ Measles: _____ Mumps: _____

Emergency Contact:

_____

Name — Address — Phone Number

Participant Consent (Adult Only)

I, _____ intend to participate in _____ date(s) _____.
In the event of an emergency, I authorize the 4-H Youth Development Representative to arrange for necessary and appropriate medical treatment which may be required during this time. I understand this authorization may also extend to travel time, to and from the event.

Participant Signature : _____ Date: _____

Parental / Guardian Consent (Youth under 18 years old only)

I give permission for (participant's name) _____ to participate in _____ date(s) _____. I understand that it may also include travel time, to and from this event, while in custody of the 4-H Youth Development representative. In the event of an emergency, I authorize the 4-H Youth Development Representative / chaperone to arrange for necessary and appropriate medical treatment which may be required during our absence.

Parent/Guardian Signature : _____ Date: _____

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