HEALTH STATEMENT

and

Parents’ Release

Arkansas 4-H

Check here if special attention is required.

County _________________________

Member’s Name ________________________________________________________________ Age ________ Sex _____

Address ______________________________________________________________________ Phone (____)____________

In case of emergency notify: Name _________________ Address _______________________ Phone (____)____________

Relationship to above member (mark one): □ Parent □ Guardian □ Other ________________

Alternate Contact in Emergency: Name _____________________________________________ Phone (____)____________

Family Physician or Clinic _________________ Address ______________________________ Phone (____)____________

Health History

Member has or is subject to: (check if yes)

□ Asthma □ Convulsions □ Fainting Spells
□ Bronchitis □ Diabetes □ Heart Trouble
□ Other (list) ___________________________________________________________________________________

Allergies or reactions to: (check those appropriate)

Drugs: □ Penicillin □ Aspirin □ Other (list) __________________________________________________________________________

Foods (what foods) __________________________________________________________________________

□ Hay fever □ Insect bites or stings □ Ivy, oak and/or sumac poisoning
□ Date of last Tetanus Immunization: ___________________ □ Tetanus antitoxin □ Tetanus toxoid

Member has difficulty with: (check if yes)

□ Eyes, ears, nose, throat □ Digestion □ Menstrual problems
□ Lungs □ Bed wetting □ Sleep walking
□ Other (list) __________________________________________________________________________

Member has a condition now requiring medication: □ Yes □ No

If yes, please indicate condition __________________________________________________________________________

Is medication in possession of member? □ Yes □ No

Name of medication __________________________________________________________________________

List any specific activities to be restricted: __________________________________________________________________________

When water sports are a part of the activity, my child may participate in:

Swimming: □ Yes □ No Diving: □ Yes □ No Canoeing or Boating: □ Yes □ No

When necessary, Extension personnel may give my child over-the-counter medications (examples: aspirin, Benadryl, Tylenol, etc.) □ Yes □ No

Parent Authorization

(Must be signed below by either Parent or Guardian.)

I understand that health services will be available and that adult supervision will be provided. If an illness or injury develops, medical and/or hospital care will be provided and I will be notified as soon as possible. I will not hold liable the University of Arkansas, the Arkansas 4-H Foundation, the Arkansas Cooperative Extension Service, or its employees for any injury or damage received by my child while he/she is being transported or is engaged in this activity.

I understand and accept the above statement and further authorize each of the following:

A. The health history listed above is correct and the above-named member has my permission to engage in all program activities except as noted.
B. I grant permission to the attending physician and/or the attendant health service staff to employ such diagnostic procedures and medical treatment as deemed necessary.
C. I authorize medical care units to release medical record information to the health insurance carrier for the 4-H events and/or the Cooperative Extension Service in order to process claims.
D. I understand that I am financially responsible for charges not covered or paid by the 4-H event insurance and hereby guarantee full payment to the attending physician(s) and/or health care unit(s).

Signature of Parent or Guardian ___________________________ Date ________________

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