HEALTH STATEMENT and Parents’ Release
Arkansas 4-H

County ____________________________ Age ________ Sex _____

Member’s Name ____________________________ Last First Initial

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 □ Bronchitis □ Hay fever □ Allergies or reactions to: (check those appropriate)

□ Convulsions □ Diabetes □ Insect bites or stings □ Drugs:

□ Fainting Spells □ Heart Trouble □ Other (list) ______________________________________________________________________

□ Tetanus toxoid □ Tetanus antitoxin □ Date of last Tetanus Immunization: ___________________

Other (list) ____________________________________________

Member has difficulty with: (check if yes)

□ Eyes, ears, nose, throat □ Lungs □ Bed wetting □ Digestion □ Menstrual problems

□ 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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