University of California Division of Agriculture and Natural Resources
4-H Youth Development Program

Youth Medical Release Form

This Medical Release Form is authorized for all 4-H Youth Development meetings and activities during the dates specified below:

_____ _____
First Name Last Name Club/Unit Name

_____ _____ to _____
County and State Dates (From / To)

While my child is attending or traveling to or from this 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, California Business and Professions Code Section 2000 et seq.; 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, California Business and Professions Code Section 1600 et seq.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. 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 4-H Accident/Sickness Insurance Program sponsored by UC Cooperative Extension.

EMERGENCY CONTACT INFORMATION

_____
Name Relationship to Youth Identified Above

(_____)_____ (_____)_____
Emergency Day Phone (with area code) Emergency Night Phone (with area code)

_____
Mailing Address City State Zip

AUTHORIZATION AND CONSENT AND RELEASE

I hereby certify that my child is in good health and can travel to and participate in all functions of the 4-H Youth Development Program as described above. I understand is it my responsibility to keep the information on this form updated (including Health History and parent/guardian status) by contacting the State 4-H Office.

_____ _____
Signature of Parent/Guardian Date

NON-CONSENT

I do not desire to sign this authorization and understand that this will prohibit my child from receiving any non-life threatening medical attention in the event of illness or accident.

_____ _____
Signature of Parent/Guardian Date

University policy and the State of California Information Practices Act of 1977 require the following information be provided when collecting personal information from you: The information entered on this form is collected under authority of the Smith-Lever Act. Submission of the medical data is voluntary. However, a signature is required on one or the other of the two signature lines above. Failure to provide the medical information and authorization may result in our inability to provide necessary medical treatment. You have the right to review University records containing personal information about you/your child, with certain exceptions as set forth in policy and statute. Copies of University policies pertaining to the collection, use, or release of personal data are available for your examination from the local UCCE County Director, 4-H Youth Development Advisor, 4-H Program Representative, or the State 4-H Director at the California 4-H Youth Development Program, University of California, DANR Building, One Hopkins Road, Davis, CA 95616-8575, (530) 754-8518. Only your own/your child's records are open to your review.

Any known or foreseeable intergovernmental transfer that may be made of the information is as follows: None.

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Health History Information

_____ _____ _____/_____/_____
First Name Last Name County Date of Birth

Subject to:	YES	No	Now Have or Have Had	Yes	No
Colds			Heart Trouble		
Sore Throat			Asthma		
Fainting Spells			Lung Trouble		
Bronchitis			Sinus Trouble		
Convulsions			Hernia (rupture)		
Cramps			Appendicitis		
Allergies			Has appendix been removed?		
Wear corrective lenses?			Do you walk in your sleep?		
Is hearing good?					
Currently under any type of medical care?					
Is there history of behavior disorders, emotional disturbances, or severe moodiness?					
Been under psychiatric treatment within the past five years?					

Date of last Tetanus Vaccination: _____

Please check over-the-counter medications that may be administered:

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

Please identify allergies including allergies to food, medications, and drug reactions:

_____
_____
_____

Please list any disabilities or disorders that may affect participation, such as: Eyesight, hearing, speech, paralysis, diabetes, ulcer, etc.

_____
_____
_____

Please list all current medications:

Name of Medication	Dosage	Times Taken

Remarks and special instructions. Please explain "yes" answers on this page.

_____
_____
_____

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