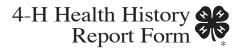
## **Virginia Cooperative Extension**



REVISED 2009 PUBLICATION 388-906

**INSTRUCTIONS:** Please provide detailed health information for determining appropriate supervision, support, and accommodations for the 4-H activity or event listed. **A parent or guardian must sign.** If the participant is a person with a disability and desires any assistive devices,

prior to the event to discuss acc		• •	•		•	-
NAME OF 4-H EVENT IN WH	IICH YOU WISH TO P	ARTICIPATE:				
DATE(S) OF EVENT:		LOCATION	N:			
PARTICIPANT IDENTIFICATION NAME:  Last		(Underline name by whic	ch you like to be called) M		FEN	MALE:   MALE:
MAILING ADDRESS:	PARTIC		CIPANT CELL PHONE: ()			
CITY:					HONE: ( )	
AGE:	BIRTHDATE: _		HOME	EMAIL:		
RACE: (Optional) WHITE	☐ HISPANIC ☐	BLACK	AMERICAN INI	DIAN 🗆	ASIAN 🗆	MULTICULTURAL
PARENT / GUARDIAN IDEN	TIFICATION (Place a c	check beside who	to reach in the eve	ent of an en	nergency.)	
☐ FATHER'S NAME (OR GUA	ARDIAN):		FATH	IER'S EMA	.IL:	
FATHER'S PHONE DAYTIME			CELL:			
□ MOTHER'S NAME (OR GUARDIAN): MOT				HER'S EMAIL:		
MOTHER'S PHONE DAYTIM	E:	EVENING	S:		CELL:	
WHO HAS PRIMARY CUSTO						
ADDRESS, IF DIFFERENT T	HAN CHILD:					
PHYSICIAN / INSURANCE INFORMATION				4-H PARTICIPANT MEDIA RELEASE		
FAMILY PHYSICIAN NAME: PHONE: ( )				The Virginia Polytechnic Institute and State University/College of Agriculture and Life Sciences (CALS) periodically uses electronic and traditional media (e.g., photographs, video, audio		
DENTIST / ORTHODONTIST NAME:						
DO YOU CARRY FAMILY ME CARRIER: POLICY ID #:			(Check √ one)	footag educa on this	je, testimonial tional purpose s form, I ackno	s) for publicity and es. By my signature owledge receipt id give permission
EMERGENCY CONTACT INFO	ORMATION (Parts 1 an	d 2 should be com	npleted)			riculture and Life
1. WHERE CAN YOU BE REACHED IN THE EVENT OF AN EMERGENCY?  LOCATION:  PHONE: ()				Sciences and its designee to use such reproductions for educational and publicity purposes in perpetuity without further consideration from me.		
CELL PHONE: ()				I unde	rstand that I v	will need to notify
2. IF YOU <b>CANNOT</b> BE REACHED, WHO SHOULD BE NOTIFIED?  NAME:  HOME PHONE: ()  WORK PHONE: ()				Virginia Tech/College of Agriculture and Life Sciences if any changes to my situation occur that will impact this media release permission.		
CELL PHONE: (			nued on back)	☐ YE	S 🗆 NO	



www.ext.vt.edu

Produced by Communications and Marketing, College of Agriculture and Life Sciences, Virginia Polytechnic Institute and State University



## PARTICIPANT HEALTH AND MEDICAL HISTORY APPROVAL / EMERGENCY AUTHORIZATION (Questions 1-5 must be completed.) (Please read parts 1 and 2. If the participant is under 18, 1. SPECIAL DIETARY NEEDS parents/guardians must sign in the space provided. If you INSTRUCTIONS: The purpose of this section is to communicate special dietary needs, are over the age of 18, please sign for yourself. If you canfood allergies, etc. for any child, teen, or adult who will be attending a 4-H event. not sign this due to religious reasons, you must contact your Extension office to obtain a legal waiver that must be signed. In the space below, please list all food allergies and/or other dietary restrictions for the person listed above and any necessary precautions that should be taken: If this section is not signed, participation in the 4-H event/activity will not be allowed. You must contact your Extension office if there is a change in health status after submitting this form. 1. I give my permission for the participant named on this form to attend the designated 4-H program. He / She has permission to participate in all activities which may include swimming and other water sports under the supervision of lifeguard(s) and to take part in other sched-2. Has the participant ever experienced (or had special needs in) any of the following? uled activities such as firearm safety, horsemanship, [Check (✔) all that apply] archery, low ropes, physical activity/exercise and related ☐ Bleeding disorders ☐ Attention disorders (ADHD) activities under the supervision of instructors; subject to ☐ Asthma ☐ Seizures/Convulsions ☐ Wears contacts ☐ Eating disorders limitations noted herein. Diabetes ☐ Bed Wetting Behavior 2. I hereby give permission to the medical staff person ☐ Fainting spells ☐ Non-food allergies Other: selected by the event/activity director to order X-rays, rou-Please describe any condition or need that you checked: tine tests and treatment for my child (or for myself if I am a participant over 18 years old) as medically necessary. I also give permission for the participant to receive overthe-counter medication as needed under the guidance of the medical staff person. I understand that all attempts will be made to notify parents/guardians of any serious injury or illness to their child. If I cannot be reached in an emergency, I hereby give permission to the medical staff person to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/ 3. Is the participant experiencing any current health problems, under medical care, or the participant named on this form. This form may be receiving mental or behavioral services, or currently taking medication? photocopied for use outside of the event/activity location. ☐ YES ☐ NO If YES, please explain: \_\_\_\_\_ ADULT PRINTED NAME: **4.** Has the participant undergone surgery, or experienced any injury, illness, allergy, or change in health status any time during the last year? Is there any reason that participation in a program or activity should be restricted? SIGNED: X\_ (Parent / Legal Guardian or participant over 18 years old) ☐ YES ☐ NO If YES, please explain: \_\_\_\_ I understand and agree to abide with any restrictions placed 5. What else should we know about your child? on my activities according to this form. 4-H programs include very rewarding, but sometimes challenging situations. Please YOUTH PRINTED NAME: inform us of any concerns that may arise related to your child's physical, mental, emotional, and/or social health in order that we may better provide appropriate supervision and support. SIGNED: X (Participant under 18 years old) Date: \_ IMMUNIZATION HISTORY (This must be completed) Are your child's immunizations up to date? ☐ YES ☐ NO Date of most recent tetanus shot: (month/year) **RELEASE AUTHORIZATION** I give permission to the following individual(s) to pick up my child at the conclusion of this 4-H event: Sign below at time of pick up (Receiving person must be pre-listed above): Signature: Name (print):