

and  
Parents' Release  
Arkansas 4-H

Check here if special attention  
is required.

County \_\_\_\_\_

Member's Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Last First Initial

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Street or Box City Zip

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 (\_\_\_\_) \_\_\_\_\_  
Street or Box City

**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 \_\_\_\_\_