



## 4-H MEMBER MEDICAL CONSENT AND RELEASE FORM

4-H Club/Program Leader keeps on file and provides as necessary to leaders of group's events.

Return to Club/Program Leader: \_\_\_\_\_

Address: \_\_\_\_\_

Name of 4-H Member:

Physical Home Address:

Mailing Address:  
(If different from physical address)

City/State/Zip:

Emergency Phone Number(s):

Name of Doctor and Phone Number(s):

Medical Conditions or Restrictions:\*

Allergies:\*

Current Medications:\*

\*Attach details if needed. Provide Leader/chaperone with updates if information changes.

As parent/legal guardian of the above individual, I permit the individual to participate in 4-H Youth Development Program sponsored activities.

I also hereby waive and forever discharge claims for damages which the above listed individual, their heirs, executors and administrators may have or accrue against Washington State University Extension, their representatives, agents and 4-H volunteers, arising from any injuries, physical or mental, suffered in connection with 4-H Youth Development Program sponsored activities during the period(s)

of: \_\_\_\_\_.

In case of a medical **EMERGENCY**, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the physician selected by the 4-H Event leader to hospitalize and secure proper treatment (including surgery) for my child.

I have read, understand and consent to the foregoing statements.

Parent/Guardian Signature(s):

Mailing Address:

City, State, Zip:

Phone(s) Day:

Evening:

**OPTIONAL:**

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_

(Not required) |

Insurance ID #: \_\_\_\_\_

**4-H Group:**

Parent/guardian attendance may be required for youth participation in some activities:

Activity(ies): \_\_\_\_\_

\_\_\_\_\_

Name of 4-H Leader: \_\_\_\_\_ Signature: \_\_\_\_\_

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WSU Extension programs and policies are consistent with federal and state laws and regulations on nondiscrimination regarding race, color, gender, national origin, religion, age, disability, and sexual orientation. Evidence of noncompliance may be reported through your local WSU

Additional details or notes:



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City/State/Zip:

Emergency Phone Number(s):

Name of Doctor and Phone Number(s):

Medical Conditions or Restrictions:\*

Allergies:\*

Current Medications:\*

\*Attach details if needed. Provide Leader/chaperone with updates if information changes.

In case of **EMERGENCY**, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the physician selected by the 4-H Event leader to hospitalize and secure proper treatment (including surgery) for my child.

I have read, understand and consent to the foregoing statements.

Parent/Guardian Signature(s):

Mailing Address:

City, State, Zip:

Phone(s) Day:

Evening:

### OPTIONAL:

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_

(not required)

Insurance ID #: \_\_\_\_\_

**OVER**

Name of 4-H Club/Program: \_\_\_\_\_

Parent/guardian attendance may be required for youth participation in some activities:

Activity(ies): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of 4-H Leader: \_\_\_\_\_ Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

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Additional details or notes: