

Parental Consent and Health Form



Washington State University 4-H Youth Development Parental Consent and Release Form

Please make 2 copies. One should be given to your chaperone.

Participant:

Last Name First Name Telephone number

Address City State Zip

As parent/legal guardian of the above individual, I hereby give my consent for the above named person to attend _____ and all related workshops and activities. I also hereby waive and forever discharge claims for damages which the above listed individual, their heirs, executors and administrators may accrue against Washington State University Cooperative Extension, their representative agents, and accompanying 4-H program leaders, arising from any injuries, physical or mental, suffered in connection with 4-H sponsored events.

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 state delegation leader to hospitalize and secure proper treatment (including surgery) for my child.

I understand, and give my consent, that any photos taken of my child participating in a 4-H event may be used in future WSU Cooperative Extension publications or printed promotional materials.

I have read, understood and agree to the above statement and do sign this agreement of my own free will.

Parent/Legal Guardian name

Parent/Legal Guardian Signature Date

Address City State Zip

Day phone Evening phone

Participant Health Form

Do you have any physical complaints or illness at this time?

___ Yes ___ No If yes, please explain: _____

Are you under the care of a physician or practitioner of any sort?

___ Yes ___ No If yes, please explain: _____

Are you taking medicines of any type?

___ Yes ___ No If yes, what? _____

In what dosage? _____

Are you on a special diet?

___ Yes ___ No If yes, please explain: _____

Do you have any of the following?

___ Diabetes? If yes, are you taking insulin/type/dosage: _____

___ Asthma? If yes, do you carry an inhaler? _____

___ Allergy? To what? _____

Last tetanus shot (month/year) _____

Other conditions or comments: _____

Physician's Name Physician's Phone Number

Health Insurance Carrier Group/Policy Number