DIVISION OF AGRICULTURE
RESEARCH & EXTENSION
University of Arkansas System

HEALTH STATEMENT
and
Parents' Release
Arkansas 4-H

FY4H633 (9/11/15)

County ___________________________

Member's Name ____ Age _____ Gender___
Last First Initial

Address ____ Phone (____)____________
Street or Box City Zip

In case of emergency notify: Name _________________ Address _______________________Phone (____)____________

Relationship to above member (mark one): O Parent O Guardian O Other ______________________________

Alternate Contact in Emergency: Name ____Phone (____)____________

Family Physician or Clinic _________________ Address ______________________________Phone (____)____________
City

Health History

Member has or is subject to: (check if yes)

O Asthma O Bronchitis O Diabetes

O Other (list) ____

Allergies or reactions to: (check those appropriate)

Drugs: O Penicillin O Aspirin O Other (list) ____

Foods (what foods) ____

O Hay fever O Insect bites or stings O Ivy, oak and/or sumac poisoning

Member has a condition now requiring medication: O Yes O No

Name of medication (dosage) ____

When necessary, Extension personnel may give my child over-the-counter medications (examples: aspirin, Benadryl, Tylenol, etc.) O Yes O No

List any specific activities to be restricted: ____

List any adaptations needed due to a disability: ____

____

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 any 4-H program or 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* ________________

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The Arkansas Cooperative Extension Service offers its programs to all youth between the ages of 5 and 19 regardless of race, color, sex, gender identity, sexual orientation, national origin, religion, age, disability, marital or veteran status, genetic information, or any other legally protected status, and is an Affirmative Action/Equal Opportunity Employer.