Georgia 4-H Medical Information & Release

Event or Activity _____ Date of Event/Activity _____

4-H'ers Information

Name _____

Address _____

Date of Birth _____ Grade _____ Gender _____

Parent/Guardian Information

Name _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please list the names of two adults other than parent/guardian who may be contacted in case of emergency.

Name _____ Home Phone _____ Work Phone _____

Name _____ Home Phone _____ Work Phone _____

Medical Information

Name of Physician _____ Phone _____

Date of Last Physical Examination _____ Drug Allergies _____

Other Allergies _____

Describe any physical limitations _____

Describe any recent illness or injury _____

Is there a history of heart condition ____ diabetes ____ asthma ____ epilepsy ____ rheumatic fever ____

PARENT/GUARDIAN AGREEMENT:

I understand that should a health problem arise, I will be notified but that if I can not be reached by telephone, such medical treatment, including surgery, as deemed necessary by competent medical personnel could be rendered; that such necessary information may be released for insurance purposes and that I understand the limitation of the coverage as indicated below. Furthermore, I am aware that participation in this event includes risk including, but not limited to, transportation to/from event, sports and recreational games, ropes courses, water activities, hiking, as well as risks that are not foreseeable. For the sole consideration of the Cooperative Extension Service's arranging for participation in 4-H programming, I hereby release and forever discharge The University of Georgia, the Board of Regents of the University System of Georgia, their members individually, and their officers, agents and employees from any and all claims, demands, rights and causes of action of whatever kind that I may have, either on my own behalf or in my capacity as a legal representative of my child, arising from or in any way connected with my child's participation in 4-H. I further covenant and agree that for the consideration stated above I will not sue the Institution, the Board of Regents of the University System of Georgia, it's members individually, its officers, agents or employees for any claim for damages arising or growing out my child's participating in the program. I understand that the acceptance of this Release, Waiver of Liability, and Convent not to Sue the Board of Regents of the University System of Georgia shall not constitute a waiver, in whole or part, of sovereign immunity by said Board, its members, officers, agents, and employees. I certify that my child is participating in 4-H with my knowledge and consent. I have read and understand all of the above policies

_____ _____

Parent/Guardian Signature **Date**

INSURANCE COVERAGE INFORMATION (to be completed by County Extension personnel)
Insurance for the event/activity has been purchased as indicated. For complete details of coverage, please contact the county Extension Office.

- ☐ Insurance for Summer Camp at Georgia 4-H Centers
- ☐ American Income Life Insurance (Plan 3)
- ☐ American Income Life Insurance (Dollar a Year Plan)
- ☐ Other Insurance Plan _____

PLEASE COMPLETE BOTH SIDES

Over the Counter & Prescription Medication Summary

4-H'ers Name _____ **County** _____

Please list any/all medication currently being taken by the 4-H club member including prescription and over the counter medications. Additionally, parent/guardian should list any over the counter medication that may be given to the 4-H'er in case of illness. 4-H personnel may not administer over the counter or prescription medication without parental/guardian approval unless prescribed by medical personnel. 4-H'ers are expected to provide all medication(s) listed and administer the medication. If health facilities and/or personnel are available at the facility, a request may be made prior to the event to have medication administered by trained personnel. Additional copies of this page may be made as necessary.

Name of Medication:

What illness/condition is medication being taken for:

Describe dosage and special instructions:

Is medication self administered?

Dates for administration:

Name of Medication:

What illness/condition is medication being taken for:

Describe dosage and special instructions:

Is medication self administered?

Dates for administration:

Name of Medication:

What illness/condition is medication being taken for:

Describe dosage and special instructions:

Is medication self administered?

Dates for administration:

I am the parent/guardian of _____and give permission for the medications listed to be administered to my child as directed.

_____ _____

Parent's signature Date

PLEASE COMPLETE BOTH SIDES