Arkansas 4-H Health Form

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 provided is correct and the 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).

CONTACT INFORMATION

Emergency Contact Parent 1 Full Name

Cell Phone

Work Phone

Emergency Contact Parent 2 Full Name

Cell Phone

Work Phone

Emergency Contact (not parent or guardian)

Relationship

Cell Phone

Work Phone

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance?

If so, name of insurance company

Group #

Name on Insurance Card

PHYSICIAN INFORMATION

City where clinic is located?

Physician's Name

Physician - Phone Number

HEALTH INFORMATION

Does your child have, or is subject to any of the following conditions?

If other, please describe

ALLERGY INFORMATION

Is your child allergic to any of the following medications? Check all that apply:

Is your child allergic to any of the following, please select all that apply:

Describe your child's allergies, including severity of reaction and other pertinent information

Is your child allergic to bees or other flying insects?

Does your child carry an Inhaler or an Epinephrine device (EpiPen)? If yes please describe the device.

Does your child have food allergies?

If yes, please select all that apply

If other, please describe

ADAPTATIONS

Are any adaptations needed due to a disability?

If yes, please describe in detail

Please list any activities your child may not participatie in:

MEDICATIONS

Does your child have a condition that requires medication?

If yes, please list the condition(s) below:

If yes, please provide the name of the medication(s), dosage, and any special instructions:

Extension personnel may give my child over-the- counter medications (Benadryl, Ibuprofen, Tylenol, etc.)