



ARIZONA 4-H YOUTH DEVELOPMENT
Parental/Guardian Consent & Release of Medical Information



PARTICIPANT'S NAME:

BIRTH DATE

Last First M.I. Month/Date/Year

ADDRESS: _____

_____ PHONE: _____

CITY ZIP

Do you have a disability for which you seek an accommodation? If so, please list your needs: _____

Emergency Medical Information :

For treatment purposes:

Name of Physician/licensed medical practioner PH#

Insurance Company Policy #

List Prescribed Medication: _____

List approved "Non-Prescription" Medications your child may be given: (aspirin, ibuprofen, cold remedies, etc.) _____

List activities prohibited due to medical conditions: _____

List allergies (food, drug, plant, insect, etc.) _____

Immunization dates (Month/Year): Tetanus: _____ Measles: _____ Mumps: _____

Emergency Contact(s):

Name Address PH#

Parental/Guardian Consent

I give permission for (participant's name) _____ to participate in (4-H Event name) _____

from (dates) _____. I understand that may also include travel time while in custody of the 4-H Youth Development representative. In the event of an emergency, I authorize the chaperon/supervisor to arrange for necessary and appropriate medical treatment which may be required during our absence.

Parent/Guardian(s) Signature Date

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