CFAES

Ohio 4-H Participant Medical Release

This form is for 4-H volunteers to use to gather an overview of critical 4-H participant information. This information will be used only for the welfare of the participant.

GENERAL PARTICIPANT INFORMATION

Name _____
(Last) (First) (Middle)

Address _____
(Street) (City) (State) (Zip)

Gender _____ Date of Birth _____ Age (January 1) _____

Primary phone number: (to use in case of cancellations, rescheduling, etc.) _____
Please mark the type of phone: ___Home ___Parent Cell ___Member Cell
Is texting on this phone ok? ___ Yes ___ No

EMERGENCY CONTACT INFORMATION

Parent/Guardian Name _____
Mobile Phone _____
Other Phone_____
Email _____

Alternate Person _____
Mobile Phone _____
Other Phone _____
Email _____

MEDICAL AND/OR OTHER ACCOMMODATIONS: Does your child have any medical needs or accommodations that would limit their ability to fully participate in the scheduled program/activity? If so, please describe these below.

_____
_____
_____
_____
_____

Please specify any restrictions in activities:

_____
_____

MEDICAL RELEASE

In the case of serious illness or injury of my child, I understand that I will be notified. If I cannot be contacted, unless otherwise specified below, I grant permission to the attending medical professional to secure proper treatment, hospitalize, and/or take any other action deemed necessary for the immediate care of my child. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Parent/Guardian Name (printed)_____

Parent/Guardian Signature_____Date_____

Participant Signature_____Date_____

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