

California 4-H Youth Development Program
Adult Medical Release Form
University of California Cooperative Extension

This Medical Release Form is authorized for 4-H functions and activities for the Club/Unit and dates specified below:

_____	_____	_____
First Name	Last Name	Club/Unit Name
_____	_____	_____ to _____
County and State	Dates (From / To)	

While I am attending or traveling to or from this 4-H function, I HEREBY AUTHORIZE THE ADULT 4-H LEADER OR STAFF MEMBER, or in his/her absence or disability, any adult accompanying or assisting him/her, TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR ME SHOULD I BE UNABLE TO MAKE A DECISION:

Any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code Section 2000 et seq.; or any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code Section 1600 et seq.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective until I complete my activities in this program unless sooner revoked in writing. I understand that I will be responsible for the cost of any service or treatment provided not covered by the 4-H Accident/Sickness Insurance Program sponsored by UC Cooperative Extension.

Authorization and Consent and Release

I hereby certify that I am in good health and can travel to and participate in all functions of the 4-H Youth Development Program as described above. I understand it is my responsibility to keep the information on this form updated (including Health History) by contacting the County 4-H Office.

_____	_____		
Signature	Date		
(_____) _____	(_____) _____		
Emergency Day Phone (with area code)	Emergency Night Phone (with area code)		
_____	_____		
Mailing Address	City	State	Zip

Non-Consent

I do not desire to sign this authorization and understand that this will prohibit me from receiving any non-life threatening medical attention in the event of an accident or illness.

_____	_____
Signature	Date

University policy and the State of California Information Practices Act of 1977 require the following information be provided when collecting personal information from you: The information entered on this form is collected under authority of the Smith-Lever Act. Submission of the medical data is voluntary. However, a signature is required on one or the other of the two signature lines above. Failure to provide the medical information and authorization may result in our inability to provide necessary medical treatment. You have the right to review University records containing personal information about you, with certain exceptions as set forth in policy and statute. Copies of University policies pertaining to the collection, use, or release of personal data are available for your examination from the local UCCE County Director, 4-H Youth Development Advisor, 4-H Program Representative or the State 4-H Director of the California 4-H Youth Development Program, University of California, DANR Building, One Hopkins Road, Davis, CA 95616-8575, (530) 754-8518. Only your own records are open to your review.

Any known or foreseeable intergovernmental transfer that may be made of the information is as follows: None.

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California 4-H Youth Development Program
Health History Information
 University of California Cooperative Extension

_____	_____	____/____/____
First Name	Last Name	Date of Birth

Subject to:	Yes	No	Now Have or Have Had	Yes	No
Colds			Heart Trouble		
Sore Throat			Asthma		
Fainting Spells			Lung Trouble		
Bronchitis			Sinus Trouble		
Convulsions			Hernia (rupture)		
Cramps			Appendicitis		
Allergies			Has appendix been removed?		
Wear corrective lenses?			Do you walk in your sleep?		
Is hearing good?					
Currently under any type of medical care?					
Is there history of behavior disorders, emotional disturbances, or severe moodiness?					
Been under psychiatric treatment within the past five years?					

Date of last Tetanus Vaccination: _____

Please identify allergies including allergies to food, medications, and drug reactions:

Please list any disabilities or disorders that may affect participation at 4-H events such as:
 eyesight, hearing, speech, paralysis, diabetes, ulcer, etc.

Please list all current medications:

Name of Medication	Dosage	Times Taken

Remarks and special instructions. Please explain "yes" answers on this page.

The University of California prohibits discrimination or harassment of any person on the basis of race, color, national origin, religion, sex, gender identity, pregnancy (including childbirth, and medical conditions related to pregnancy or childbirth), physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, or status as a covered veteran (covered veterans are special disabled veterans, recently separated veterans, Vietnam era veterans, or any other veterans who served on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized) in any of its programs or activities.

University policy is intended to be consistent with the provisions of applicable State and Federal laws.

Inquiries regarding the University's nondiscrimination policies may be directed to the Affirmative Action/Staff Personnel Services Director, University of California, Agriculture and Natural Resources, 300 Lakeside Drive, 6th Floor, Oakland, CA 94612-3550, (510) 987-0096.