

Washington County 4-H Shooting Sports

Consent of Parents

Medical Care and Treatment Form

This form must be completed for each participant each year when enrolled in the 4-H Shooting Sports Program. *This information will be kept confidential and used only for the welfare of the participant.*

Date _____ please Circle: Male Female Birth Date _____ Age _____

Youth Name _____

Address _____
last first
number and street city state zip

In case of emergency contact:

Parent/Guardian name _____ Phone (____) _____

Work Phone (____) _____

Other ways to contact, cell phone (____) _____ Pager _____

Contact person if parent not available _____ Phone (____) _____

Relationship to child _____

Physician's Name /Clinic _____ Phone(____) _____

Health Insurance Company _____ Policy# _____

-
- > **Requests for reasonable accommodations for disabilities or limitations should be made prior to participation in the shooting sports project. These project members may not be participating in the same way as other youth members.**

----- 4-H Health Statement -----

Health History (check all that apply; giving appropriate dates where needed)

Bronchitis _____ Convulsions/seizures _____

Fainting _____ Kidney trouble _____

Diabetes _____ Heart Condition _____

Recent Operations or Injuries _____ Ear Infection _____

Asthma (controlled yes, no) _____ Behavior Problems _____

Participant is allergic to:

- Foods (specify) _____ Tape? _____ Rubber Gloves? _____ Latex ? _____
- Medication: prescription or non-prescription drugs: Penicillin? _____ Aspirin? _____
- Tetanus ? _____ Other? _____
- Serious Ivy, Oak or Sumac Poisoning _____ Bee or Insect stings _____
- Explain allergic reaction to allergies listed above _____
_____ Prescribed Treatment _____

Present dietary regulations _____

Present Medications _____

Any specific activities to be restricted? _____

***IMMUNIZATIONS: **Tetanus: Date of last treatment _____ (must be completed)

Parent/Guardian Medical Release

This health history is correct as far as I know and the person herein described has permission to engage in all prescribed activities, except as noted in writing by me and the physician. In case of medical emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I give my permission to the physician selected by the adult leader in charge to hospitalize and/or secure proper treatment for my child as named above. I, as the parent or legal guardian, give my consent. I assume complete responsibility for incomplete, incorrect, or lack of information on this form. I do not hold the 4-H volunteers, UW-Extension Staff/Employees, University of Wisconsin, donors, other participants or the organization providing and/or sponsoring range/meeting facilities responsible for accidents arising out of this program. *I understand that as the parent/ guardian signing this form that I will be held financially responsible for any expenses above and beyond what the 4-H insurance will pay.* I will notify in writing the volunteer/adult leader in charge if there is any changes in my child's health condition and/or medications.

(signature of parent/guardian) Date _____