

**H. Emergency Medical Release**

In consideration of \_\_\_\_\_'s (participiant's name) participation in the 4-H activity or event, I provide the following release. I understand that a health problem or a medical emergency may develop that necessitates the administration of medical care, hospitalization or surgery.

In the event of injury or illness to \_\_\_\_\_ (participiant's name), I hereby authorize the University of Tennessee, Tennessee State University, and its representative(s) or agent(s) to secure any necessary treatment, including the administration of anesthetics and surgery.

In signing this acceptance form at the bottom of this page, I agree not to hold the University of Tennessee, Tennessee State University, or camp health care professional (or any of its representatives or agents) responsible for any side effects of medications.

I further give permission to the University of Tennessee, Tennessee State University, and its representative(s) or agent(s) to provide the medical history form to health care personnel. I authorize any physician, health care provider or any hospital to provide reasonable and necessary medical treatment or supplies. This original permission or a photo static copy thereof is equally valid as an authorization.

I recognize that the event does not provide sickness or accident insurance coverage for participants; and, I accept responsibility for payments of medical costs incurred for injuries or illnesses.

**Required Signatures\* - Parent/Guardian and Participant**

We have provided accurate information in all areas represented on this form. We understand and agree to the expectations and procedures as stipulated in the preceding sections of this ACTIVITY AND EVENT ACCEPTANCE FORM. We understand that all of the following sections must be initiated to demonstrate our agreement and acceptance and a full, dated signature must be provided at the bottom of this page.

Parent's Initials	and	Participant's Initials
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____

\* If for religious reasons you cannot sign this section, contact your Extension office for a legal waiver (F600C) which must be signed in order to participate.

I have read this Release and Assumption of Risk Agreement and sign it on behalf of myself, my heirs, assigns and anyone entitled to act on my behalf.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian Signature) (Month/Day/Year)

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Participant's Signature) (Month/Day/Year)

Programs in agriculture and natural resources, 4-H youth development, family and consumer sciences, and resource development. University of Tennessee Institute of Agriculture and county governments cooperating. UT Extension provides equal opportunities in programs and employment. Revised 7/19

**E. Health and Safety Investigations**

On-site authorities may enter a room/facility for purposes of a search without permission of the person occupying a room in order to ascertain health and safety conditions in the room and/or for the purpose of investigating suspected violations of UT and TSU Extension/4-H Youth Development rules and regulations and/or city, state or federal law. In case of an emergency, when there is danger to a person, property or the building, no authorization is required.

**F. Consent for First Aid Treatment**

Please complete this Consent for First Aid treatment form. This will allow appropriate treatment for your child in the event of minor illness or injury. Check any or all treatments, if available, as your consent. If you do not give us your permission to provide these non-emergency treatments, we will not be able to provide them to your child. Medication may be self-administered under a health care professional's or trained 4-H agent's supervision as appropriate. Conditions in parentheses are examples of the most frequent use of these medications, but may not be the sole use of the medication.

- Bausch and Lomb eye wash or generic equivalent (eye irritation)
- Bandy® or generic equivalent (rash or bee sting)
- Calamine lotion/Caladryl® or generic equivalent (sunburn or poison oak/ivy)
- Emetrol® or generic equivalent (nausea)
- Hydrocortisone ointment or other equivalent (insect bites)
- Ibuprofen (pain)
- Imodium AD® or generic equivalent (diarrhea)
- Isodotes® spray or generic equivalent (sore throat)
- Lanacne® spray, Soltrate® or aloe vera gel (sunburn)
- Milk of Magnesia®, Mylanta®, or generic equivalent (antacid)
- Neosporin® or generic equivalent (topical treatment for cuts)
- Pepto Bismol® or generic equivalent (upset stomach)
- Robitussin® or generic equivalent (nasal congestion/coughing)
- Swimmer's ear solution (earache)
- Tylenol® or generic equivalent (pain)
- Tylenol® cold tablets or generic equivalent (congestion)

**G. Administration of Medication**

Check here if your child, \_\_\_\_\_, will have medication(s) (prescription or non-prescription) and is competent to self-administer them under appropriate supervision. (Name of Participant)

Medications should be sent to the event or activity in the original container and include the following information: (1) Name of child, (2) Name of medication, (3) Dosage and directions, (4) Name of licensed prescriber (if applicable), (5) Name, address and phone number of pharmacy (if applicable), (6) Prescription number (if applicable), and (7) Date prescription was filled (if applicable).

If your child is a participant at one of the Tennessee 4-H Centers (Camps), you must include a parental consent form for each medication (prescription or non-prescription) you send with your child. Please consult your County Extension Agent for a form and more information.

**Activity and Event Acceptance Form**



Print name of participant on this line: \_\_\_\_\_  
 (Last) (First) (Initial)  
 This form requires parent/guardian and participant signatures on the back page. Failure to have both bona fide signatures will be sufficient to disqualify a member from further participation.  
 This form is for \_\_\_\_\_  
 (event or activity)

**Identification of Participant**

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex:  Male  Female  
 Parent or Guardian Name \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 (Street/P.O. Box) (City) (State) (ZIP)  
 Phone ( ) \_\_\_\_\_ Daytime Phone ( ) \_\_\_\_\_ Nighttime Phone ( ) \_\_\_\_\_  
 Workplace Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 (Address/City/State/ZIP)  
 Emergency Contact (if appropriate) \_\_\_\_\_  
 (Name) \_\_\_\_\_  
 (Address/City/State/ZIP) \_\_\_\_\_  
 (Phone, if different than above)

**Code of Conduct**

- 4-H activity or event is planned, conducted and supervised by UT and TSU Extension. All participants are responsible for their conduct to UT and TSU Extension personnel and/or 4-H volunteers supervising the activity or event. Specific guidelines for conduct include:
- A. Participants shall be in their rooms and quiet at the time determined by UT and TSU Extension personnel and volunteers. Boys are not to go into girls' rooms and girls are not to go into boys' rooms at any time unless accompanied by authorized UT and TSU Extension personnel or adult 4-H volunteers.
  - B. Participants shall participate fully in all programs outlined for the activity or event.
  - C. Participants shall show respect for the property and facilities used during the activity or event and assume financial responsibility for any damages they cause.
  - D. Participants' conduct at all times shall be appropriate to the standards and image of the 4-H program. Tobacco products, drugs, alcohol, weapons and fireworks will not be tolerated at any 4-H event or activity.

Participants and parents understand and accept the responsibility for following the above guidelines, and realize that failure to do so may result in a participant being sent home from the activity or event at his or her own expense and/or being ineligible to participate in future 4-H events or activities.

**Publicity Release**

By signing this form, participants authorize the University of Tennessee, Tennessee State University, and the Tennessee 4-H Foundation to photograph, film, audio/video tape, record and/or televise their image, voice, and biographical material, in whole or in part in any medium now known or developed in the future, without any restrictions.

**D. Health History and Medical Record for** \_\_\_\_\_

The information on this form will not be used to discriminate against a child on the basis of any disability. (Name of Participant)  
 Name of Family Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Family Medical/Hospital \_\_\_\_\_ (Carrier) \_\_\_\_\_ (Policy or Group #)

Attach a front and back copy of your insurance card below:

Insurance Card (front)	Insurance Card (back)
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Check all that apply  
 Is participant allergic to the following drugs?  
 Penicillin  Sulfa Drug  Tetracycline  Aspirin  
 Allergy to a medicine, food, plant, or insect toxin. (Explain) \_\_\_\_\_  
 Asthma  Heart Trouble  Nosebleeds  Diabetes  Convulsions  Fainting Spells  
 Any condition that may require special care, diet or restriction of activities for medical reasons. (Explain) \_\_\_\_\_  
 Does participant wear:  Dentures  Contact Lens  Other (Explain) \_\_\_\_\_  
 Is any medication, including behavior modification medication, being taken at the present time?  Yes  No  
 If yes, explain \_\_\_\_\_  
 Date of most recent medical examination: \_\_\_\_\_  
 Are you aware of any current health problems?  Yes  No If yes, explain \_\_\_\_\_

Is there any accident, illness or past/present history related to the following: (If yes, give dates and full details below.)

	No		Yes		Year		No		Yes		Year
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Serious Injury/Illness	<input type="checkbox"/>	<input type="checkbox"/>				Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>			
Surgery	<input type="checkbox"/>	<input type="checkbox"/>				Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>			
Ears, Eyes	<input type="checkbox"/>	<input type="checkbox"/>				Back, Joints, Limbs	<input type="checkbox"/>	<input type="checkbox"/>			
Teeth, Tonsils	<input type="checkbox"/>	<input type="checkbox"/>				Blood	<input type="checkbox"/>	<input type="checkbox"/>			
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>				Stomach	<input type="checkbox"/>	<input type="checkbox"/>			

Immunizations	Last Yr. Given	Immunizations	Last Yr. Given	Has Had (please check)
Tetanus	_____	Measles	_____	<input type="checkbox"/> Measles
Diphtheria	_____	Mumps	_____	<input type="checkbox"/> Mumps
Polio	_____	Rubella	_____	<input type="checkbox"/> Rubella
Hepatitis A, B or C	_____	Varicella	_____	<input type="checkbox"/> Chicken Pox
(circle one/any)				<input type="checkbox"/> Tuberculosis