Georgia 4-H Medical Information & Release Form
This form should be completed prior to each 4-H event.

EVENT: _____ Date(s) of EVENT: _____

4-H'ers Information

Name _____ County _____

Address _____

Date of Birth _____ Grade _____ Gender _____ Preferred Phone _____

Parent/Guardian Information

Name: _____ Preferred Phone: _____ Alt. Phone: _____
Email Address: _____ Text: _____

Name: _____ Preferred Phone: _____ Alt. Phone: _____

Please list the names of two adults other than parent/guardian who may be contacted in case of emergency.

Name: _____ Preferred Phone: _____ Alt. Phone: _____

Name: _____ Preferred Phone: _____ Alt. Phone: _____

Medical Information

The following information is requested in case of accident or illness to better treat your child.
The information is optional and not required for participation.

Name of Physician: _____ Phone: _____

Date of Last Physical Examination: _____ Drug Allergies: _____

Other Allergies: _____

Describe any recent illness or injury: _____

Describe any pre-existing conditions: _____

Describe any other circumstances that would help leaders or medical professionals in working with the 4-H'er:

_____

_____

PARENT/GUARDIAN AGREEMENT:

I understand that should a health problem arise, I will be notified but that if I can not be reached by telephone, such medical treatment, including surgery, as deemed necessary by competent medical personnel could be rendered; that such necessary information may be released for insurance purposes and that I understand the limitation of the coverage as indicated below. Furthermore, I am aware that participation in 4-H programming includes risk including, but not limited to, transportation to/from events, sports and recreational games, ropes courses, water activities, hiking, as well as risks that are not foreseeable. For the sole consideration of the Cooperative Extension Service's arranging for participation in 4-H programming, I hereby release and forever discharge The University of Georgia, the Board of Regents of the University System of Georgia, their members individually, and their officers, agents and employees from any and all claims, demands, rights and causes of action of whatever kind that I may have, either on my own behalf or in my capacity as a legal representative of my child, arising from or in any way connected with my child's participation in 4-H. I further covenant and agree that for the consideration stated above I will not sue the Institution, the Board of Regents of the University System of Georgia, it's members individually, its officers, agents or employees for any claim for damages arising or growing out of my child's participating in the program. I understand that the acceptance of this Release, Waiver of Liability, and Convent not to sue the Board of Regents of the University System of Georgia shall not constitute a waiver, in whole or part, of sovereign immunity by said Board, its members, officers, agents, and employees. I certify that my child is participating in 4-H with my knowledge and consent. I have read and understand all of the above policies. I hereby grant permission for my child's images, likeness, and voice to be recorded in any media during this program and to be used by the University of Georgia and Georgia 4-H on behalf of the Board of Regents of the University System of Georgia in any publications, media, or technology now known of or hereby developed in the future for any lawful purpose whatsoever without further permission from me. I understand I will not be compensated further for use of these recordings.

_____ _____
Parent/Guardian Signature **Date**

PLEASE COMPLETE BOTH SIDES

Over the Counter & Prescription Medication Summary

4-H'ers Name _____ **County** _____

Parent/guardian should list any over-the-counter medication that may be given to the 4-H'er in case of illness. In addition, list any/all medication routinely taken by the 4-H'er including prescription and over the counter medications.

Check Yes or No to indicate if you allow your child to receive the following medications while participating in 4-H programming.

1. Administration of Acetaminophen (Tylenol ®) or Ibuprofen (Motrin ® or Advil ®) at an age appropriate or weight appropriate dose for discomfort, pain, or fever
   ☐Yes ☐ No *** Parent/Guardian will be contacted if student's fever is 100° F or higher.
2. Antacid liquid or Antacid tablets for indigestion/minor stomach discomforts and at an age appropriate dose
   ☐Yes ☐No
3. Diphenhydramine (Benadryl®) for symptoms of allergic reactions, insect stings, or rashes at an appropriate dose
   ☐Yes ☐No
4. Sore throat relief spray for sore throat
   ☐Yes ☐No
5. Cough Drops for coughing
   ☐Yes ☐No
6. Itch and rash relief cream/ointment for minor skin irritations
   ☐Yes ☐No
7. Lubricating eye drops for eye irritations
   ☐Yes ☐No
8. Oral pain relief gel for tooth/mouth discomfort
   ☐Yes ☐No
9. Triple antibiotic ointment for minor skin abrasions/wounds
   ☐Yes ☐No

Please list any prescription, over-the-counter, or homeopathic medications your child is currently taking. This information is necessary if your child is to be treated by a medical professional. Examples: Claritin, vitamins, etc. If the following medication should be administered during this event, complete the Georgia 4-H Medicine Form. Any medications brought to a program must be in its original container, unexpired, and clearly labeled with the 4-H'ers name. Youth may not share any medication with others.

All medications should be turned in to program/activity leaders at the program start and should accompany a Georgia 4-H Medicine Form. Any exceptions to this (such as an inhaler for asthma or an epi-pen for allergic reactions) must be verified with a 4-H staff member prior to the event.

Medication	**Condition being treated for**

I am the parent/guardian of _____and give permission for the medications listed to be administered as directed. By signing below, I am agreeing the information is currently correct. I agree to notify 4-H immediately in writing should any of this information change. I also understand that I will be notified if my child distributes or shares any prescription, over-the-counter, or homeopathic medication, or if my child is found to be in possession of any medications not listed on this form.

_____ _____

Parent/Guardian Signature **Date**

Georgia 4-H Medicine Form

This form should accompany any medication to be given at an event.

Name of 4-H'er: _____

County:_____ Date(s): _____

Activity where medication may be administered:

_____

Please list any medication(s) your child will be taking while at the above event. (Attach additional page if necessary).

Name of Medication: _____

Illness/condition medication is being taken for: _____

Date(s) medication is to be given: _____ Time: _____

Describe what the medication looks like? _____

Describe dosage and special instructions: _____

My child will be taking the above noted prescription or over-the-counter medication that I am providing while they are involved in the above activity. I understand that any medications brought to a program must be in its original container, unexpired, and clearly labeled with the 4-H'er's name.

Parent/Guardian Signature:_____**Date:**_____

To be completed by administering leader

Date	Time	Leader initials	4-H'er initials	Notes

Georgia 4-H Medicine Form – Additional Page – Name of 4-H'er: _____

Name of Medication: _____

Illness/condition medication is being taken for: _____

Date(s) medication is to be given: _____ Time: _____

Describe what the medication looks like? _____

Describe dosage and special instructions: _____

My child will be taking the above noted prescription or over-the-counter medication that I am providing while they are involved in the above activity. I understand that any medications brought to a program must be in its original container, unexpired, and clearly labeled with the 4-H'er's name.

Parent/Guardian Signature: _____

To be completed by administering leader

Date	Time	Leaders initials	4-H'ers initials	Notes

Name of Medication: _____

Illness/condition medication is being taken for: _____

Date(s) medication is to be given: _____ Time: _____

Describe what the medication looks like? _____

Describe dosage and special instructions: _____

My child will be taking the above noted prescription or over-the-counter medication that I am providing while they are involved in the above activity. I understand that any medications brought to a program must be in its original container, unexpired, and clearly labeled with the 4-H'er's name.

Parent/Guardian Signature: _____

To be completed by administering leader

Date	Time	Leader initials	4-H'er initials	Notes