

Washington State 4-H Shooting Sports
Consent of Parents

Medical Care and Treatment Form

This form must be completed for each participant 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 Last Name _____ First Name _____

Address _____

In case of emergency contact:

Parent/Guardian name _____ Phone () _____

Work Phone() _____

Other Ways to contact: Cell Phone () _____ Pager () _____

Contact Person if Parent is not available _____

Relationship to child _____ Phone () _____

Physician's Name/ Clinic _____ Phone () _____

Health Insurance Company _____ Policy# _____

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Requests for reasonable accommodations for disabilities or limitations should be made prior to participation in the shooting sports program of or event. These project members may not be participating in the same way as other youth members.
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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 Infections
Asthma (controlled yes, no) _____ Behavior Problems

Participant is allergic to:

Foods(specific) _____ 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 _____

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 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 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, WSU and or it's staff, 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 prior to any event or activity.*

Signature of Parent/Guardian _____ Date _____