4-H MEDICAL INFORMATION AND INFORMED CONSENT FOR TREATMENT FOR NC 4-H AND WAKE COUNTY SPONSORED EVENTS

PLEASE READ AND COMPLETE THE FOLLOWING FORM. THIS FORM MUST BE PRESENTED AT THE OFFICIAL REGISTRATION FOR THE 4-H SPONSORED EVENT BEING ATTENDED. THIS FORM MUST BE NOTARIZED.

Name of 4-H Group/Unit: _____ **Date:** _____

Member Name: _____
Last Name First Name Middle Initial

Address: _____ _____
Street Address City State Zip Code

Phone: (____) _____ **Email:** _____ County: WAKE

I. Medical Information

Known allergies to foods, drugs, insect stings or bites, etc: _____

_____

Special medical concerns or conditions that event supervisors should know about, including contagious illnesses, epilepsy, asthma, diabetes, previous injuries to bones/joints, etc: _____

_____

_____

List special dietary needs: _____

Medications currently being taken (name of medication dose and frequency): _____

_____

Family Physician: Name _____ Phone # (____)_____

Address: _____

II. Insurance Information

The 4-H program purchases insurance for youth participants for many sponsored events. In some cases, this coverage will not pay for some medical expenses and it may be necessary to bill the family or your insurance company.

Health Insurance Company _____

Health Insurance Policy # _____

Company Address _____

Company Telephone Number (_____) _____

III.

If you are a person with a disability and desire any assistive devices, services, or other accommodations to participate in this activity, please contact the offices of Wake County Cooperative Extension Center at (919) 250-1100 during business hours of 8:30a.m. to 5:15p.m. to discuss accommodations at least one business week prior to activity.

Signatures Acknowledging Parts I, II, III

Parent's/Guardian's Signature _____ Date: _____

Participant's Signature: _____ Date: _____

Parent/Guardian telephone #: Home: (____)_____ Work: (____)_____

Must be completed each year by 4-H'er and Parent/Guardian. If health history changes within that year, it is the 4-H'er & Parent/Guardian's responsibility for updating information.

Approved as of 3/02/05

IV. Informed Consent

In the event that a participant needs minor medical care from 4-H or more significant medical care from a qualified health care provider, including in rare cases possible hospitalization and/or surgery, the parent/guardian is asked to sign the informed consent form below. In case of serious medical condition, 4-H will make every effort to notify the parents, but the first priority may be providing care to the participant.

Authorization to Consent to Health Care for Minor

I, _____, of Wake County, am the custodial parent having legal custody

of _____ a minor child, age _____, born, _____

(N*ame of 4-H youth participant)* *(Youth participant birth date)*

I authorize any adult(s) acting as agents (including official volunteers) or employees of the Wake County 4H program and in whose care the minor child has been entrusted, to do any acts which may be necessary or proper for the health care of the minor child including, but not limited to, the power (1) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (2) to consent to and authorize any health care including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining, procedures.

This consent shall be effective for one year from the date of execution.

Custodial Parent Signature _____Date_____

STATE OF NORTH CAROLINA
COUNTY OF WAKE

On this _____day of _____ (*month*), _____ (*year*),_____

personally appeared before me the named, _____, to me known and
(Parent/Guardian)
known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledged that he (or she) executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

My Commission Expires: _____, 20_____

_____, Notary Public
Signature

_____
Printed Name

(OFFICIAL SEAL).

http://www.wakegov.com
http://wake.ces.ncsu.edu