

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

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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 of my Regents of the University purpose whatsoever without further permission from me. I understand I will not

Parent/Guardian Signature

Date

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 or over the counter 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.

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.

Parent/Guardian Signature

Date