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 b 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_____