OFFICIAL 4-H HEALTH FORM Rev. 6-2015

Name of Event/Activity: Migrant Middle School Camp

PLEASE WRITE IN CLEAR FORM AND COMPLETE ALL THE SPACES IN BLANK

Type of activity: ❑**County/area** ☒ **state** ❑ **regional** ❑ **national** (Select the "state" option)

Name of event/activity: Migrant Middle School Camp County:_____

Participant's Name: _____ _____ _____
Last First Middle

Address: _____
Street Address

_____ _____ _____
City State Zip Code

Participant is: ❑Adult ❑Youth ❑Male ❑Female School Grade:_____

Birth Date: _____ Home Phone: _____ Cell Phone: _____

Emergency Contact:_____ _____
Name Relationship

_____ _____
Daytime phone Evening phone

_____ _____
Cell phone Other

Health Statement: (to be completed by parent, physician or adult participant)

Does the participant have any dietary restrictions? If yes, please describe:	Si	No
Does the participant have any allergies? If yes, please describe:	Si	No
Name of all medications the participant is taking:		
Name and phone number of physician:		

As parent or guardian, if my child needs medical attention, I understand every effort will be made to contact me. I hereby give permission to the medical personnel selected by the person in charge of the 4-H event to order x-rays, routine tests, treatment, release any records necessary, and to provide or arrange necessary related transportation for the person named on this form. I hereby give permission to the physician selected by the person in charge of the 4-H event to hospitalize, secure emergency treatment for, to order injection, anesthesia, and/or surgery for me, or my child as named on this form. I will assume all financial obligations incurred if not covered by insurance.

_____ _____
Signature of Parent/Guardian or Adult participant Date