MONTANA STATE UNIVERSITY | EXTENSION

Medical Release Form for 4-H Youth & Adults

PARTICIPANT INFORMATION

Name:_____County:_____

Address:_____Birthdate:_____

Name of Parent or Legal Guardian (YOUTH): _____

Primary Physician:_____Phone:_____

Dentist:_____Phone: _____

IN CASE OF EMERGENCY

Primary Contact:_____Phone:_____

Relationship:_____City:_____State:_____

Alternate Contact:_____Phone:_____

Relationship:_____City:_____State: _____

INSURANCE INFORMATION

Name of Insurance Carrier:_____

Policy Holder:_____Policy #:_____

DATE OF LAST VACCINE

Tetanus:_____Polio:_____Mumps:_____Measles:_____Rubella: _____

MEDICAL INFORMATION (Check all that apply & Explain if necessary):

_____ Stomach/Intestinal Problems   _____Heart Disease   _____Currently Under Doctor's Care
_____ Diabetes or Hypoglycemia   _____Allergies to Medications   _____Currently Taking Medications
_____ Nervous Disorders   _____Allergies to Food or Plants   _____Physical Restrictions/Medical
_____ Respiratory Problems   _____Special Diet/Food Restrictions Problems that Require Special Care

Explain any checked above: _____

_____

AUTHORIZATION FOR TREATMENT (YOUTH ONLY):

I,_____do hereby give permission to: _____
       PARENT/GUARDIAN NAME   CHAPERONE NAME

Parent/Guardian Signature:_____Date: _____

ALL PARTICIPANTS

To the best of my knowledge, accurate information has been provided in all areas of this form.

Participant Signature (youth/adult)_____Date:_____

IF YOUTH Parent/Guardian Signature_____Date: _____