Waukesha County 4-H Shooting Sports
Consent of Parents
Medical Care and Treatment Form

This form must be completed for each participant each year 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 Name ____
last first

Address ____
number and street city state zip

In case of emergency contact:

Parent/Guardian name ______________________________________ Phone (______)________________

____ Work Phone (_____)______________

Other ways to contact, cell phone (____)____________________Pager___________________________

Contact person if parent not available____________________________ Phone (_____)_______________

Relationship to child ___________________________

Physician's Name /Clinic ____________________________ Phone(_____)___________

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Health Insurance Company ____ Policy#___________

- **Requests for reasonable accommodations for disabilities or limitations should be made prior to participation in the shooting sports project. These project members may not be participating in the same way as other youth members.**

------------------------------ 4-H Health Statement------------------------------

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 Infection __________________

Asthma (controlled yes, no) ____________ Behavior Problems __________________

Participant is allergic to:

- Foods (specify)______________________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 be restricted? ____

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*****IMMUNIZATIONS: ***Tetanus: Date of last treatment_________________ (must be completed)**

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 medical 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 the 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, UW-Extension Staff/Employees, University of Wisconsin, 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.

____ **Date**____________________

(signature of parent/guardian)