

# Medical Release Form for 4-H Youth & Adults

## Participant Information:

Name: \_\_\_\_\_ County: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Parent or Legal Guardian: (YOUTH ONLY) \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

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## In Case of Emergency

Primary Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

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## Insurance Information

Name of Insurance Carrier: \_\_\_\_\_

Policy #: \_\_\_\_\_

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## Date of Last:

Tetanus Shot: \_\_\_\_\_ Polio Shot: \_\_\_\_\_ Mumps Shot: \_\_\_\_\_

Measles Shot: \_\_\_\_\_ Rubella Shot: \_\_\_\_\_

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## Medical Information: (check all that apply and explain if necessary)

Stomach or Intestinal problems \_\_\_\_\_

Diabetes or hypoglycemia (low blood sugar) \_\_\_\_\_

Nervous disorder (convulsions, epilepsy, dizziness, ect.) \_\_\_\_\_

Respiratory problems \_\_\_\_\_

Heart Disease \_\_\_\_\_

Any allergies to medication \_\_\_\_\_

Any allergies to food or plants \_\_\_\_\_

Special diet or food restrictions \_\_\_\_\_

Are you currently under a doctor's care? \_\_\_\_\_

Are you currently taking medications? \_\_\_\_\_

Are there any physical restrictions or medical problems that may require special considerations? \_\_\_\_\_

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**Authorization for Treatment (YOUTH ONLY)**

I, \_\_\_\_\_ do hereby give permission to \_\_\_\_\_  
*Parent or Guardian NAME* *Chaperone NAME*

to seek and obtain any medical care necessary for my child \_\_\_\_\_  
*Youth Participant NAME*

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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**All Participants**

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

Adult Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

**OR**

Youth Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



**MONTANA**  
STATE UNIVERSITY

EXTENSION



Montana 4-H Center  
FOR YOUTH DEVELOPMENT