

Livingston County
Parent or Guardian Consent/Medical Treatment Authorization Form

There are two places on these forms that must be signed by a parent or guardian of a minor participant or by participants aged 18 and up.

Club _____

SECTION I – PARENT/GUARDIAN CONSENT

Required for youth under age 18 to participate.

I hereby grant permission for my child (print name)

_____ to participate in all educational and social activities of 4-H sponsored by Michigan State University Extension's 4-H Youth Development.

Name of Parent/Guardian (Please print)

Signature: _____

Date: _____

SECTION II – MEDICAL TREATMENT AUTHORIZATION

This section must be completed and signed by a parent or guardian for all youth participants before they can participate in 4-H activities. If this form is not completed, youth participants will not be allowed to participate. For adult participants, completing this section is optional but encouraged.

Please complete this form to give a medical facility permission to treat the participant for minor injuries or medical problems. In the event of serious injury or illness, the parent or person designated will be contacted. Treatment will proceed before contacting the parent or person designated only if the situation is urgent and does not permit delay.

Participant's name _____

Birthdate _____ Phone () _____

Address _____

Social security number _____

Primary care physician's name _____

Physician's address _____

Physician's phone () _____

HEALTH INSURANCE INFORMATION:

Policy holder's name and relationship to participant _____

Policy holder's address _____

Please attach a photocopy of both sides of your insurance card or provide the following information.

Insurance company's name and address _____

If you have HMO insurance, please list the emergency treatment authorization phone number

Phone () _____

Employer's name and address _____

Business phone () _____

Subscriber's social security number _____

All policy numbers (please identify) _____

INFORMATION NEEDED ABOUT PARTICIPANT:

Please circle yes or no. If yes, explain below or on another sheet if you need more room.

YES NO Does the participant have any chronic health problem or illness?

YES NO Does he or she have any acute illness now?

YES NO Has the person been treated recently for some medical problem?

YES NO Does the participant have any allergies to medication or local anesthetics?

YES NO Does he or she have any allergies?

List any medications he or she is now taking for treatment of any medical problem.

Date of his or her last tetanus shot _____

OFFICIAL AUTHORIZATION FOLLOWS:

I (parent or legal guardian), _____ recognize that while attending 4-H programs, medical treatment on an emergency basis may be necessary for my child, and I further recognize that MSU 4-H staff or volunteer may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the circumstances and to assume the expenses of such care. I also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature of Parent/Guardian of minor participant or of participant aged 18 and up. _____

Date _____

Address _____

Phone: Day () _____

Evening () _____