

MEDICAL TREATMENT FORM

University of California 4-H Youth Program

YOUTH

I hereby certify that my child is in good health and can travel to and participate in this 4-H function.

My Child _____
name of child

has my permission to attend the **4-H Kid's Night**

located near Grace Church, **Mariposa County**

between the dates of **March 22, 2013**

While my child is attending or traveling to or from this function, **I HEREBY AUTHORIZE THE ADULT 4-H LEADER OR STAFF MEMBER**, or in his/her absence or disability, any adult accompanying or assisting him/her, **TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR SAID MINOR.**

Any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code section 2000 et seq.; or any X-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code section 1600 et seq.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective until my child completes his/her activities in this program unless sooner revoked in writing. I understand that as a parent/legal guardian, I will be responsible for the cost of any service or treatment provided not covered by the 4-H Youth Accident Insurance Program sponsored by the University of California Cooperative Extension.

AUTHORIZATION AND CONSENT AND RELEASE

_____ date _____ signature

Should there be any changes in the status of parent/legal guardian, it will be my responsibility to keep the County 4-H Office informed.

NON-CONSENT

I do not desire to sign this authorization and understand that this will prohibit my child from receiving any medical attention in the event of illness or accident.

_____ date _____ signature

ADULT

(This information is confidential and will be used only in case of emergency.)

Name _____
name of adult

Event: **4-H Kid's Night**

Located near Grace Church, **Mariposa County**

between the dates of **March 22, 2013**

I hereby certify that I am in good health and can travel to and participate in this 4-H function.

While I am attending or traveling to or from this 4-H function, **I HEREBY AUTHORIZE THE ADULT 4-H LEADER OR STAFF MEMBER**, or in his/her absence or disability, any adult accompanying or assisting him/her, **TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR ME SHOULD I BE UNABLE TO MAKE A DECISION:**

Any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code section 2000 et seq.; or any X-Ray Examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code section 1600 et seq.

AUTHORIZATION AND CONSENT

_____ date _____ signature

NON-CONSENT

I do not desire to sign this authorization and understand that this will prohibit my receiving any medical attention in the event of illness or accident.

_____ date _____ signature

University policy and the State of California Information Practices Act of 1977 requires the following information be provided when collecting personal information from you: The information entered on this form is collected under authority of the Smith-Lever Act. Submission of the medical data is voluntary. However, a signature is required on one or the other of the two signature lines above. Failure to provide the medical information and authorization may result in our inability to provide needed medical treatment. You have the right to review University records containing personal information about you/your child, with certain exceptions as set forth in policy and statute. Copies of University policies pertaining to the collection, use, or release of personal data are available for your examination at the Division of Agriculture and Natural Resources, 4-H, DANR, One Shields Avenue, University of California, Davis, California 95616-8565. Only your own/your child's records are open to your review. Any known or foreseeable intergovernmental transfer which may be made of the information is as follows: None.

HEALTH HISTORY INFORMATION

(This information is confidential and will be used only in case of emergency.)

Name of Participant: _____ Date of Birth: _____

Is participant subject to:	Yes	No	Does participant have or ever had:	Yes	No
Colds			Heart trouble		
Sore throat			Asthma		
Fainting spells			Lung trouble		
Bronchitis			Sinus trouble		
Convulsions			Hernia (rupture)		
Cramps			Appendicitis		
Allergies			Has participant's appendix been removed?		
			Does participant sleep walk?		
			Is participant now under medical care?		
Is there any history of behavior disorders or emotional disturbances, such as difficulties in relationships with authority figures or peers, or abnormally severe moodiness?					
Has participant been under psychiatric treatments within the last three years?					

If participant is a minor, please identify over-the-counter medications that we may administer to your child. For example: Antacid, "Tylenol".

Date of last Tetanus Vaccination: ____/____/____

Please identify participant's allergies, including **allergies to food**, medications, or drug reactions you know about:

Please list any disabilities or disorders that may affect participant's participation at this 4-H function, such as eyesight, hearing, speech, paralysis, diabetes, ulcer, etc.

Please list all medications that are presently being taken by participant:

<i>Name of Medication</i>	<i>Dosage</i>	<i>Times Taken</i>

Remarks and any special instructions: _____

The University of California prohibits discrimination against or harassment of any person on the basis of race, color, national origin, religion, sex, physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, or status as a covered veteran (special disabled veteran, Vietnam-era veteran or any other veteran who served on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized). University Policy is intended to be consistent with the provisions of applicable State and Federal laws. Inquiries regarding the University's nondiscrimination policies may be directed to the Affirmative Action/Staff Personnel Services Director, University of California, Agriculture and Natural Resources, 1111 Franklin, 6th Floor, Oakland, CA 94607-5200 (510) 987-0096.

Issued in furtherance of Cooperative Extension work, Acts of May 8 and June 30, 1914, in cooperation with the U.S. Department of Agriculture. Daniel M. Dooley, Director of Cooperative Extension, University of California.