



4-H MEMBER MEDICAL CONSENT AND RELEASE FORM

MEMBER CODE: _____
 (To be completed by Club Leader)

Please Print Legibly

Name of 4-H Member:	
Home Address:	
City/State/Zip:	
Emergency Telephone Number: ())	
Name of Doctor:	Telephone Number: ())
Physical Conditions or Restrictions:	
Allergies:	
Current Medications:	

As parent/legal guardian of the above individual, I permit the individual to participate in 4-H Youth Development Program sponsored activities.

I also hereby waive and forever discharge claims for damages which the above listed individual, their heirs, executors and administrators may have or accrue against Washington State University Cooperative Extension, their representatives, agents and accompanying 4-H volunteers, arising from any injuries, physical or mental, suffered in connection with 4H Youth Development Program sponsored activities during the period(s) of: _____.

I also approve of emergency care (including hospitalization and surgery) for the above individual, under the direction of the event leader or consulting doctor, even if I cannot be contacted. I have read, understand and agree to the above listed statement and do sign this agreement of my own free will.

Parent/Guardian Signature:	Date:
Home Address:	
City/State/Zip:	
Home Telephone: ())	Work:
4-H Club Name:	
Name of Medical Insurance Carrier:	
Medical Insurance Identification Number:	

Cooperating agencies: Washington State University, U.S. Department of Agriculture and Snohomish County. Cooperative Extension programs and employment are available to all without discrimination. Evidence of noncompliance may be reported through your local Cooperative Extension Office.