MONTANA STATE UNIVERSITY | EXTENSION

Medical Release Form for 4-H Youth & Adults

PARTICIPANT INFORMATION

Name:_____ County:_____

Address: _____

Name of Parent or Legal Guardian (YOUTH): _____

Primary Physician: _____ Phone: _____

Dentist: _____ Phone: _____

IN CASE OF EMERGENCY

Primary Contact:_____ Phone: _____

Relationship: _____ City: _____ State: _____

Alternate Contact:_____ Phone: _____

Relationship: _____ City: _____ State: _____

INSURANCE INFORMATION

Name of Insurance Carrier:_____

Policy Holder: _____ Policy #: _____

DATE OF LAST VACCINE

Tetanus: _____ Polio: _____ Mumps: _____ Measles: _____ Rubella: _____

MEDICAL INFORMATION (Check all that apply & Explain if necessary):

_____ Stomach/Intestinal Problems
_____ Diabetes or Hypoglycemia
_____ Nervous Disorders
_____ Respiratory Problems
_____ Heart Disease
_____ Allergies to Medications
_____ Allergies to Food or Plants
_____ Special Diet/Food Restrictions
_____ Currently Under Doctor's Care
_____ Currently Taking Medications
_____ Physical Restrictions/Medical Problems that Require Special Care

Explain any checked above: _____

_____

AUTHORIZATION FOR TREATMENT (YOUTH ONLY):

I, _____ do hereby give permission to: _____
PARENT/GUARDIAN NAME CHAPERONE NAME

Parent/Guardian Signature: _____ Date: _____

ALL PARTICIPANTS

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

Participant Signature (youth/adult) _____ Date: _____

IF YOUTH Parent/Guardian Signature _____ Date: _____