

Washington State 4-H Shooting Sports  
Consent of Parents

Medical Care and Treatment Form

This form must be completed for each participant when enrolled in the 4-H Shooting Sports program. *This information will be kept confidential and used only for the welfare of the participant.*

Date \_\_\_\_\_ Please Circle: Male Female Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Youth Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_

**In case of emergency contact:**

Parent/Guardian name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Work Phone( ) \_\_\_\_\_

Other Ways to contact: Cell Phone ( ) \_\_\_\_\_ Pager ( ) \_\_\_\_\_

Contact Person if Parent is not available \_\_\_\_\_

Relationship to child \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Physician's Name/ Clinic \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Policy# \_\_\_\_\_

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**Requests for reasonable accommodations for disabilities or limitations should be made prior to participation in the shooting sports program of or event. These project members may not be participating in the same way as other youth members.**  
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**Health History (check all that apply: giving appropriate dates where needed)**

\_\_\_\_\_ Bronchitis \_\_\_\_\_ Convulsions/ seizures \_\_\_\_\_ Fainting  
\_\_\_\_\_ Kidney Trouble \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Condition  
\_\_\_\_\_ Recent Operations or Injuries \_\_\_\_\_ Ear Infections  
Asthma (controlled yes, no ) \_\_\_\_\_ Behavior Problems

**Participant is allergic to:**

Foods( specific) \_\_\_\_\_ Tape? \_\_\_\_\_ Rubber Gloves? \_\_\_\_\_

Latex? \_\_\_\_\_ Medication: prescription or non prescription drugs: Penicillin? \_\_\_\_\_ Aspirin? \_\_\_\_\_

Tetanus? \_\_\_\_\_ Other? \_\_\_\_\_

Serious Ivy, Oak or Sumac Poisoning \_\_\_\_\_ Bee or Insect stings \_\_\_\_\_

Explain allergic reaction to allergies listed above \_\_\_\_\_

Prescribed Treatment \_\_\_\_\_

Present dietary regulations \_\_\_\_\_

Present Medications \_\_\_\_\_

Any specific activities to be restricted? \_\_\_\_\_

**Immunizations; Tetanus: Date of last treatment** \_\_\_\_\_

**Parent/Guardian Medical Release**

This health history is correct as far as I know and the person herein described has permission to engage in all prescribed activities, except as noted in writing by me, and the physician. In case of emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I give my permission to the physician selected by the adult leader in charge to hospitalize and/or secure proper treatment for my child as named above. I, as parent or legal guardian, give my consent. I assume complete responsibility for incomplete, incorrect, or lack of information on this form. I do not hold the 4-H volunteers, WSU and or it's staff, donors, other participants or the organization providing and/or sponsoring range/meeting facilities responsible for accidents arising out of this program. *I understand that as the parent/guardian signing this form that I will be held financially responsible for any expenses above and beyond what the 4-H insurance will pay. I will notify in writing the volunteer/adult leader in charge if there is any changes in my child's health condition and or medications prior to any event or activity.*

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