



Iowa 4-H Medical Information/Release Form (Adult)

_____ Year

Keep original in County Office.

PARTICIPANT INFORMATION

Participant's Name _____

Permanent Address _____

City, State, Zip _____

Date of Birth _____ Gender _____

Home Phone _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to Contact First

Name _____

Relation to Participant _____

Daytime Phone _____

Evening Phone _____

E-mail _____

Name of Family Doctor _____

Name of Dentist _____

Backup Contact (Relative or Friend)

Name _____

Relation to Participant _____

Daytime Phone _____

Evening Phone _____

E-mail _____

Office Number _____

Office Number _____

INSURANCE POLICY INFORMATION

The above-named participant is covered by health insurance. Yes** No*

* If no, initial this line stating that you do not have health insurance and are aware that Iowa State University/University Extension/4-H does not carry any health insurance for you. _____

** If yes, provide the following information which is required by Iowa State University to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name _____ P.H.'s Date of Birth _____

Address _____ Relation to Participant _____

City, State, Zip _____ Occupation _____

P.H.'s Employer's Name/Address _____

Insurance Company Name _____

Policy # _____ Plan # _____

HEALTH INFORMATION (Please Print)

Do you have any of the following conditions or a history of any of the following conditions? (**Check all that apply.**)

- | | | |
|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Heart or cardio-vascular problems/disease |
| <input type="checkbox"/> Convulsions/seizure | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Chronic bone, muscle or joint injuries |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Other condition(s): (Please list) _____ | |

Allergies or reactions: (**Check all that apply.**)

- | | | | | |
|---|---|---|---------------------------------|----------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Dairy | <input type="checkbox"/> Gluten | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Insect bites or stings | <input type="checkbox"/> Ivy/oak/sumac toxins | <input type="checkbox"/> Other (list) _____ | | |

Are you currently on any prescribed or over-the counter medication? (If so, please record the condition/ailment, name of medication, dosage, time(s) of day, prescribing physician.)

.....
Date of last tetanus shot (approximate if necessary): _____

(over)

TO BE READ AND SIGNED BY PARTICIPANT

BEHAVIOR EXPECTATIONS OF THE PARTICIPANT

It is important to follow the directions of the ISU Extension staff member or volunteer at all times. I understand that as a participant I have the responsibility to help make the activity a safe experience for everyone through my behavior and conduct. I also understand the danger of not following rules and directions and agree to follow them.

Participant Signature

Date

I understand that I must be healthy and reasonably fit in order to safely participate in ISU Extension/4-H activities and that I will inform the program leader(s) of any medication, ailment, condition, or injury that may affect my ability to participate safely.

MEDICAL EMERGENCY PERMISSION*

The health history is correct and complete to my knowledge. If an injury or other medical condition occurs or arises, I hereby give permission to the ISU Extension staff or volunteer to provide routine first aid and seek emergency treatment including x-rays or routine tests. I agree to the release of any record necessary for treatment, referral, billing or insurance purposes. I understand that I am financially responsible for charges and hereby guarantee full payment to the attending physicians or health care unit. In the event of an emergency where I cannot decide for myself, I give permission to the physician/hospital selected by the ISU Extension staff or volunteer to secure and administer treatment for me, including hospitalization. (*If you cannot sign this section of the form for any reason, contact the County Extension Director regarding a legal waiver in order to attend and participate.) _____initial _____date

PUBLICITY/IMAGE/VOICE PERMISSION

The Iowa State University Extension 4-H Program normally takes photographs, video, and/or tape recording of our programs. During activities, a photograph or video/audio recording may be taken of you. Unless you request otherwise, your initial below will be considered permission for Iowa State University and the 4-H Program to photograph, film, audio/video tape, record and/or televise your image and/or voice for use in any publications or promotional materials, in any medium now known or developed in the future without any restrictions. If you object to ISU using your image or voice in this manner, please notify the ISU Extension staff member or volunteer. _____initial _____date

TRANSPORTATION PERMISSION

I understand that if personally-owned vehicles are used as transportation to and from Iowa State University Extension (ISUE) and 4-H events or activities, that the owner of the vehicle is responsible for any liability that might occur during the transportation. ISU does not provide coverage for any property damage, personal injury or liability that may occur while using personal vehicles. Vehicle owners are required to carry automobile liability insurance as required by the State of Iowa. _____initial _____date

4-H ASSUMPTION OF RISK AND RELEASE OF LIABILITY (*Please read carefully.*)

I understand that ISUE project activities/events may involve certain risks of physical activity and possible injury and that Iowa State University and its 4-H program will provide each participant with reasonable care, but that ISU cannot guarantee that I will remain free of injury. In addition, some 4-H projects including but not limited to: shooting sports, horse or livestock projects, water activities, and other sporting activities have a higher degree of risk. I nonetheless wish to participate in the ISU Extension event/activity and ASSUME the RISK of participating. I agree to RELEASE from LIABILITY, INDEMNIFY and HOLD HARMLESS the State of Iowa, the Board of Regents of the State of Iowa, ISU and ISU Extension and their officers, employees and agents (hereinafter the RELEASEES) from any and all claim and/or cause of action arising out of and related to any injury, loss, penalties, damage, settlement, costs or other expenses or liabilities that occur as a result of my participation in the ISUE program. This release, however, is not intended to release the above-mentioned RELEASEES from liability arising out of their sole negligence.

Participant Signature

Date

IOWA STATE UNIVERSITY
Extension and Outreach

... and justice for all
The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, and marital or family status. (Not all prohibited bases apply to all programs.) Many materials can be made available in alternative formats for ADA clients. To file a complaint of discrimination, write USDA, Office of Civil Rights, Room 326-W, Whitten Building, 14th and Independence Avenue, SW, Washington, DC 20250-9410 or call 202-720-5964.

Issued in furtherance of Cooperative Extension work, Acts of May 8 and June 30, 1914, in cooperation with the U.S. Department of Agriculture. Cathann Kress, Director, Cooperative Extension Service, Iowa State University of Science and Technology, Ames, Iowa.