KENTUCKY STATE UNIVERSITY
Cooperative Extension Program 4-H Youth Development

Medical Information and Authorization

PARENT/GUARDIAN AUTHORIZATION AND RELEASE

TO BE COMPLETED BY PROGRAM STAFF:

Program/Event Name: _____

Date(s):_____ County/Location: _____

Employee Name: _____ Program Area: _____

SECTION 1. PARTICIPANT & EMERGENCY CONTACT INFORMATION

Participant information

Participant Name: _____

Date of Birth: ____ / ____ / _____ Gender: □ M □ F

Parent/Guardian Information

Parent/Guardian Name: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

ADDITIONAL EMERGENCY CONTACT

Primary Emergency Contact (if different from parent/guardian)

Name: _____

Phone: _____ Alternate Phone: _____

Relationship: _____

SECONDARY EMERGENCY CONTACT

Name: _____

Phone: _____ Alternate Phone: _____

Relationship: _____

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PARTICIPANTNAME:_____

SECTION 2. MEDICAL INFORMATION

Family Physician: _____

Physician Phone: _____

Health Insurance Carrier: _____

Policy Number: _____

□ Copy of insurance card attached

Allergies / Medical Conditions

Dietary Considerations or Special Needs

Current Medications

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SECTION 3. HEALTH HISTORY (Please check Yes or No)

Hospitalized in the past? □ Yes □ No
Surgery of any kind? □ Yes □ No
Currently taking medications? □ Yes □ No
Allergies (medications, food, insects)? □ Yes □ No
Fainted during exercise? □ Yes □ No
Dizziness during or after exercise? □ Yes □ No
Chest pain during or after exercise? □ Yes □ No
High blood pressure? □ Yes □ No
Heart murmur? □ Yes □ No
Rapid heartbeat episodes? □ Yes □ No
Family history of heart problems before age 50? □ Yes □ No
Skin problems? □ Yes □ No
Head injury? □ Yes □ No
Loss of consciousness? □ Yes □ No
Seizures or epilepsy? □ Yes □ No
Nerve injuries? □ Yes □ No
Heat-related illness? □ Yes □ No
Dizziness in heat? □ Yes □ No

Breathing issues during activity? □ Yes □ No
Use of medical equipment? □ Yes □ No
Vision problems? □ Yes □ No
Bone/joint injuries? □ Yes □ No
Missing paired organ? □ Yes □ No
Asthma diagnosis? □ Yes □ No
Use of inhaler? □ Yes □ No
Diabetes? □ Yes □ No
Use insulin? □ Yes □ No
Tobacco use? □ Yes □ No
Family history of sickle-cell anemia? □ Yes □ No
Other medical problems? □ Yes □ No
Injury in the last year? □ Yes □ No

Explain any "Yes" responses:

_____
_____
_____
_____
_____
_____

Additional Information

Can the participant swim? □ Yes □ No
Date of last tetanus shot: _____

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SECTION 4. MEDICATION ADMINISTRATION PROCEDURES

The 4-H Youth Programs follow a Medication Administration Procedure to protect all participants and staff.

Prescription Medications

- Must be in original containers with proper instructions
- Must be listed on the Medication Form
- Must be labeled with participant name
- Will be stored and administered by authorized staff only
- Daily medication logs will be maintained

Over-the-Counter Medications

- Cannot be administered without parent/guardian permission
- Must be provided and listed on the Medication Form

Emergency Situations

- 911 will be contacted immediately
- Parent/guardian will be notified

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PARTICIPANTNAME:_____

SECTION 5. PERMISSION TO ADMINISTER MEDICATIONS

Medication #1

Medication Name: _____

Dosage: _____

Expiration Date: ____ / ____ / _____

Refrigerate: □ Yes □ No

Times: ____ AM/PM ____ AM/PM ____ AM/PM ____ AM/PM

Special Instructions: _____

Possible Reactions: _____

Medication #2

Medication Name: _____

Dosage: _____

Expiration Date: ____ / ____ / _____

Refrigerate: □ Yes □ No

Times: ____ AM/PM ____ AM/PM ____ AM/PM ____ AM/PM

Special Instructions: _____

Possible Reactions: _____

Medication #3 (if needed)

Medication Name: _____

Dosage: _____

Expiration Date: ____ / ____ / _____

Refrigerate: □ Yes □ No

Times: ____ AM/PM ____ AM/PM ____ AM/PM ____ AM/PM

Special Instructions: _____

Possible Reactions: _____

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PARTICIPANTNAME:_____

SECTION 6. MEDICAL AUTHORIZATION

I authorize Kentucky State University and YEA staff to provide routine healthcare or first aid, administer medications as listed, and seek emergency medical treatment if necessary.
I understand that:

- I am responsible for any medical expenses incurred
- I will be notified in case of emergency

Parent/Guardian Name (print): _____

Signature: _____

Date: _____

FOR PROGRAM/CAMP STAFF USE ONLY

Medications Received By: _____

Date: _____

Notes: _____

_____

_____

_____