

**Mercer County 4-H
Medical Authorization**

Date: _____



Participant Name: _____
Last First Middle I.

Address: _____
Street
City State Zip

Participant's Social Security No.: _____ Age: _____ Date of Birth: _____

Parent/Guardian Name(s): _____

Business Phone: Mother: _____ Step Mother: _____
Father: _____ Step Father: _____

Home Phone: Mother: _____ Step Mother: _____
Father: _____ Step Father: _____

Cell Phone/Pager: Mother: _____ Step Mother: _____
Father: _____ Step Father: _____

Neighbor or Relative (Other than parent/guardian): _____
Name Phone

MEDICAL INFORMATION:

Name of Family Physician: _____
Phone

Name of Dentist: _____
Phone

Date of last physical examination: _____ Date of last tetanus immunization: _____

Drug allergies: _____

Medical Conditions: Heart Condition _____ Diabetes _____ Asthma _____
Rheumatic Fever _____ Epilepsy _____

Are there any restrictions on physical activity? _____
If so, what are they? ? _____

CONSENT TO MEDICAL TREATMENT:

It is understood that authority is given to the University of Kentucky, or anyone they may designate, to have my son/daughter treated for injuries or illnesses they incur during a designated 4-H activity/event.

I understand that I will be notified of a health problem arises, but in the event I cannot be reached by telephone, I hereby give the University of Kentucky, or anyone they may designate, permission to seek medical treatment for the above-named participant, including surgery & on an emergency basis) or additional advanced treatments (MRI, lab tests, etc.) As deemed necessary by competent medical personnel.

I am aware that, as the parent or legal guardian of the above-named participant, I will be responsible for any expenses incurred.

Signature (Parent/Guardian if claimant is a minor, under 18)

Date

Submit a copy of the front & back of all insurance and Rx identification cards.