California 4-H Youth Development Program
ADULT MEDICAL TREATMENT FORM

(This information is confidential and will be used only in case of emergency.)

NAME: ______________________________ COUNTY: ______________________________

EVENT: ______________________________ SITE: ______________________________

COUNTY/STATE: ______________________ DATES: ______________/______________
from to

I hereby certify that I am in good health and can travel to and participate in this 4-H function.

While I am attending or traveling to or from this 4-H function, **I HEREBY AUTHORIZE THE ADULT 4-H LEADER OR STAFF MEMBER,** or in his/her absence or disability, any adult accompanying or assisting him/her, **TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR ME SHOULD I BE UNABLE TO MAKE A DECISION:**

> Any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code section 2000 et seq.; or any X-Ray Examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code section 1600 et esq.

AUTHORIZATION AND CONSENT

______________ ______________________________ In the event of an emergency, please contact
DATE SIGNATURE

the following person: ____

ADDRESS: ____

DAY PHONE: (_____)____________________ NIGHT PHONE: (_____)____________________

NON-CONSENT

I do not desire to sign this authorization and understand that this will prohibit my receiving any medical attention in the event of illness or accident.

______________ ______________________________
DATE SIGNATURE

University policy and the State of California Information Practices Act of 1977 requires the following information be provided when collecting personal information from you: The information entered on this form is collected under authority of the Smith-Lever Act. Submission of the medical data is voluntary. However, a signature is required on one or the other of the two signature lines above. Failure to provide the medical information and authorization may result in our inability to provide needed medical treatment. You have the right to review University records containing personal information about you/your child, with certain exceptions as set forth in policy and statute. Copies of University policies pertaining to the collection, use, or release of personal data are available for your examination at the Division of Agriculture and Natural Resources, 4-H, DANR, One Shields Avenue, University of California, Davis, California 95616-8565. Only your own/your child's records are open to your review. Any known or foreseeable intergovernmental transfer which may be made of the information is as follows: None.

______________ ______________________________
DATE SIGNATURE

Continued on Back

California 4-H Youth Development Program
ADULT HEALTH HISTORY INFORMATION

NAME: ____________________________ DATE OF BIRTH: ______ / ______ / ______
Month Day Year

Are you subject to:	Yes	No	Do you now have or have you ever	Yes	No
Colds			Heart trouble		
Sore throat			Asthma		
Fainting spells			Lung trouble		
Bronchitis			Sinus trouble		
Convulsions			Hernia (rupture)		
Cramps			Appendicitis		
Allergies			Has your appendix been removed?		
Is your eyesight good?			Do you walk in your sleep?		
Is your hearing good?			Are you now under medical care?		
Is there any history of behavior disorders or treatment for emotional disturbances?					
List when you were last vaccinated for tetanus:				/ / (M D Y)	

Please identify your allergies, including allergies to food, medications, or drug reactions you know about:

____

Please list any physical disabilities or disorders that may affect your participation at this 4-H function, such as eyesight, hearing, speech, paralysis, diabetes, ulcer, etc.

____

____

Please list all medications that you are presently taking:

Name of Medication *Dosage* *Times Taken*

____

____

____

Remarks and/or any special instructions:

____

____

____

The University of California prohibits discrimination against or harassment of any person on the basis of race, color, national origin, religion, sex, physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, or status as a covered veteran (special disabled veteran, Vietnam-era veteran or any other veteran who served on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized). University Policy is intended to be consistent with the provisions of applicable State and Federal laws. Inquiries regarding the University's nondiscrimination policies may be directed to the Affirmative Action/Staff Personnel Services Director, University of California, Agriculture and Natural Resources, 1111 Franklin, 6th Floor, Oakland, CA 94607-5200 (510) 987-0096.

Issued in furtherance of Cooperative Extension work, Acts of May 8 and June 30, 1914, in cooperation with the U.S. Department of Agriculture. W.R. Gomes, Director of Cooperative Extension, University of California.

Revised 2/00