



Florida 4-H Participation Form



Note: This form must be completed by the participant and/or parent or guardian in order to participate in the 4-H program. **All items must be completed, even if the response is not applicable – indicate by using N/A (for example: no health insurance).** This form must be present while traveling to, and during each event.

Failure to complete this form in its entirety will result in the person being ineligible to participate in 4-H activities.

Name _____ Birth Date ____/____/____ Age _____ Youth _____ Adult _____
 Last First Month / Day / Year Female Male
 Home Address _____ County/District _____/_____
 City ST Zip _____ FL _____ Home Phone () _____
 Primary Emergency Contact _____ Work Phone () _____
 Email _____ Cell Phone () _____
 Alternate Emergency Contact _____ Phone () _____

Name of Family Doctor _____ Phone () _____
 Health Insurance Company _____ Policy # _____
 Name of Insured _____ Relationship to Participant _____

HEALTH HISTORY

Does the participant have, or at any time had, any of the following? Check "Yes" or "No" to each item. Please explain any "Yes" answers (noting the # of the item) in the space below or on an additional sheet of paper if necessary. Reporting conditions will not prevent a person from attending and will be kept confidential.

	Yes	No	Please explain "Yes" answers and provide information on recent medical issues (including injuries and surgeries), allergic reactions, special dietary regulations, present medications, any specific activities to be restricted and other comments.
1) Asthma.....			_____
2) Bronchitis.....			_____
3) Convulsions.....			_____
4) Diabetes.....			_____
5) Ear Infection.....			_____
6) Fainting.....			_____
7) Heart Condition.....			_____
8) Headaches.....			_____
9) Hypoglycemia.....			_____
10) Serious Insect Stings.....			_____
11) Wear Glasses.....			_____
12) Wear Contact Lenses.....			_____
13) Other Conditions.....			_____
14) Penicillin Allergy.....			_____
15) Aspirin Allergy.....			_____
16) Tetanus Allergy.....			_____
17) Other Drug Allergies.....			_____
18) Food Allergies.....			_____
19) Serious Ivy, Oak, or Sumac.....			_____
20) Other Allergies.....			_____
21) Other Health Conditions.....			_____
Date of Last Tetanus Shot ____/____/____			

The following over-the-counter medications may be administered to my child, without contacting me:
 Antihistamine Antacid Ibuprofen (Advil) Acetaminophen (Tylenol)
 Decongestant Dramamine Hydrocortisone Polysporin (topical antibiotics)
 Other _____ Please contact me for permission to administer ANY over-the-counter medications.

PUBLICITY RELEASE

I authorize UF IFAS Extension and the Florida 4-H Foundation or their assignees to record and photograph my image and/or voice (or that of my child, if under 18) for use in research, educational and promotional programs. I also recognize that these audio, video and image recordings are the property of UF IFAS Extension and/or the Florida 4-H Foundation.

No, I do not authorize use of my – or my child's – individual image or voice.

Directions for Florida 4-H Participation Form

This form is to be completed at least once per year for all 4-H members. Adults are required to use this form for state events and activities. All participants should review and update their form before each out-of-county event. Below are explanations for sections where questions are anticipated.

Date of Birth and Age: Optional for adults.

Primary Emergency Contact: Parent or Guardian of youth; Spouse, or other contact for adults.

County/District: Where participant is enrolled or registered for 4-H; not necessarily the county they live in.

Home Address: Participant's primary mailing address.

E-mail: Optional, but useful for activity coordinators

Alternate Emergency Contact: Someone other than the Primary Emergency Contact. Please include their phone number to the right of their name.

Family Doctor: If consultation is needed, please include the doctor's phone number to the right of their name.

Name of Insured: List the individual who the insurance is provided through. Relationship could be: self, father, mother, spouse, etc. Please note the event's insurance will only cover a portion of the individual's medical costs and you, or your personal insurance, may be responsible for additional expenses

Health History: This section is important to help the activity coordinators and health care providers be aware of serious or special medical issues and diagnose problems. It is the parents' or participants' responsibility to keep this and other sections current. Please use the blank/lined section to provide details on any serious conditions that need explanation. **Be sure to include any medications the participant is currently using**

Publicity Release: Only needs to be checked if the participant refuses to allow their voice or image to be recorded.

Survey and Evaluation Release: This preliminary permission only needs to be checked if the participant refuses to be involved in any program evaluation.

Youth/Adult Code of Conduct: All participants (regardless of age) must read and sign this section. Adults are included in this section for the purpose of maintaining effective role models and chaperones.

Verification: Must be signed by adult participants, parents, or guardians. Youth participants 18 years and older may sign, but a parent or guardian signature is preferred.

This form must be present for all participants at each event and while traveling to these events. Check with your County Extension Office for county specific information.