Youth Health History & Treatment Authorization Form - Print all information clearly. (page 1)
(PAGE SUBMITTED TO AND RETAINED BY THE COUNTY 4-H OFFICE, COPY SHARED WITH 4-H CLUB/UNIT LEADER; SHRED AFTER THE PROGRAM YEAR)

This Treatment Authorization is authorized for all 4-H Youth Development meetings and activities during the dates specified below. (Please Note: This information must be updated annually)

Dates Valid: **July 1, 2024 to December 31, 2025**

While my child is attending or traveling to or from this 4-H function, I HEREBY AUTHORIZE THE 4-H ADULT VOLUNTEER OR 4-H STAFF MEMBER, or in their absence or disability, any adult accompanying or assisting them, TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR SAID MINOR:

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 seq.

This authorization is given pursuant to the provisions of California Family Code Section 6910. This authorization shall remain effective until my child completes their activities in this program unless sooner revoked in writing. I understand that as a parent/guardian, I will be responsible for the cost of any service or treatment provided not covered by the 4-H Accident/Sickness Insurance Program sponsored by UC Cooperative Extension.

University policy and the State of California Information Practices Act of 1977 require 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. Failure to provide the medical information and authorization may result in our inability to provide necessary medical treatment. You have the right to review University records containing personal information about you, 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 from the local UCCE County Director, 4-H Youth Development Advisor, 4-H Community Education Specialist (CES), 4-H CES Supervisor or the Statewide 4-H Director at University of California, Division of Agriculture and Natural Resources, California State 4-H Office, 2801 Second Street, Davis, CA 95618-7774, (530) 750-1334, ca4h@ucanr.edu. Only your own records are open to your review.

Member Information:

*Legal First Name _____ *Legal Last Name _____
*Date of Birth _____ *County _____

PARENT(S)/GUARDIAN(S)

Parent/Guardian 1			
*First Name		*Last Name	
*Phone			
Parent/Guardian 2			
First Name		Last Name	
Phone			

EMERGENCY CONTACT INFORMATION:

*First Name: *Last Name:
*Relationship: *Phone:

Health History:

***Allergies**

Does the participant have any allergies, including allergies to food, medications, and drug reactions?
☐ Yes, details provided below ☐ No

_____

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***Youth First and Last Name (Print)**	

***Authorized Medications**
Please check over-the-counter medications that may be administered: (if available)

☐ Pain/fever reliever (ex. Tylenol) ☐ Allergy medication (ex. Benadryl) ☐ Motion sickness/nausea medication
☐ Antacid ☐ Cough Suppressant ☐ Anti-itch Cream
☐ Antibiotic ointment ☐ Decongestant ☐ Ibuprofen (ex. Advil)
☐ Other: (Provided by parent/guardian) _____

*Does the participant take any medications currently? ☐ Yes, details provided below ☐ No

Name of Medication	Dosage	Times Taken

***Conditions**
Does this participant have any health conditions that are important for program staff to know in order to maximize participation and ensure safety and well-being? ☐ Yes, details provided below ☐ No

_____

***Remarks**
Does the participant need any additional assistance in order to participate in this program or activity?
Note: in some cases, a Doctor's note may be required to confirm the request.
☐ Yes, details provided below ☐ No

_____

Does the youth have any current emotional or behavioral difficulties that would be helpful for us to know about?
☐ Yes (If Yes, explain) ☐ No

_____

Would you like to share any significant life or family events that will help us support the youth's current emotional state?
☐ Yes (If Yes, explain) ☐ No

_____

Are there any ways of responding to the youth's negative moods or feelings that you found to be effective?
☐ Yes (If Yes, explain) ☐ No

_____

Are there any additional remarks and special instructions to better assist emergency service personnel?
☐ Yes (If Yes, explain) ☐ No

_____

Immunizations (This section is only for members attending 4-H Camp. CA 4-H YDP does not collect information on vaccination status or history unless the youth member will be attending camp.)

Is the youth vaccinated for Tetanus? ☐ Yes ☐ No	**If yes, provide date received:**

Please list all other immunizations received:

Immunization	Date Received

Youth Health History & Treatment Authorization - Print all information clearly. (page 3)

***Youth First and Last Name (Print)**	

Treatment Authorization: *Must select Consent or Non-Consent Option:

☐ **AUTHORIZATION AND CONSENT AND RELEASE**

I hereby certify that my child is in good health and can travel to and participate in all functions of the 4-H Youth Development Program as described above. I am the parent/guardian having legal custody of the youth member named above as stated under California Family Code Section 6550. I understand it is my responsibility to keep the information on this form updated (including Health History) by contacting the County 4-H Office.

☐ **NON-CONSENT**

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

*Parent/Guardian Full Name (Print)	
*Signature of Parent/Guardian (if youth is 18 years old, may sign for self)	*Date