

# Activity and Event Acceptance Form

Please print

Name \_\_\_\_\_  
(Last) (First) (M.)

County \_\_\_\_\_

*This form requires parent/guardian and participant signatures on the back page. Failure to have both bonafide signatures shall be sufficient to disqualify a member from further participation.*

Activity and Event Acceptance Form for \_\_\_\_\_  
(event or activity)

## A. Identification of Participant

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex:  Male  Female

Parent or Guardian \_\_\_\_\_

Home Address \_\_\_\_\_  
(Street/P.O. Box) (City) (State) (Zip)

Cell Phone (\_\_\_\_) \_\_\_\_\_ Daytime Phone (\_\_\_\_) \_\_\_\_\_ Nighttime Phone (\_\_\_\_) \_\_\_\_\_

Work Place Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
(Address/City/State/Zip)

Other Emergency Contact (if appropriate) \_\_\_\_\_  
(Name)

\_\_\_\_\_ (\_\_\_\_)  
(Address/City/State/Zip) (Phone, if different than above)

## B. Code of Conduct

This 4-H activity or event is planned, conducted and supervised by UT Extension. All participants are responsible for their conduct to UT Extension personnel and/or 4-H volunteers supervising the activity or event. Specific guidelines for conduct include:

- A. Participants shall be in their rooms and quiet at the time determined by UT Extension personnel and leaders. Boys are not to go into girls' rooms and girls are not to go into boys' rooms at any time unless accompanied by authorized UT Extension personnel or adult 4-H volunteers.
- B. Participants shall participate fully in all programs outlined for the activity or event.
- C. Participants shall show respect for the property and facilities used during the activity or event and assume financial responsibility for any damages they cause.
- D. Participants' conduct at all times shall be appropriate to the standards and image of the 4-H program. Tobacco products, drugs, alcohol, weapons and fireworks will not be tolerated at any 4-H event or activity.

Parents and participants understand and accept the responsibility for following the above guidelines, and realize that failure to do so may result in a participant being sent home from the activity or event at his or her own expense and/or made ineligible to participate in future 4-H events or activities.

## C. Publicity Release

By indication of signature on the last page, participants authorize the University of Tennessee to photograph, film, audio/video tape, record and/or televise their image and voice, and biographical material, in whole or in part in any medium now known or developed in the future, without any restrictions.

## D. Health History and Medical Record for \_\_\_\_\_

(Name of Participant)

The information on this form will not be used to discriminate against a child on the basis of any disability.

Name of Family Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Family Medical/Hospital Insurance \_\_\_\_\_  
 (Carrier) \_\_\_\_\_ (Policy or Group #)

**Attach a front and back copy of your insurance card below.**

|                        |                       |
|------------------------|-----------------------|
| Insurance Card (front) | Insurance Card (back) |
|------------------------|-----------------------|

**Check all that apply**

Is participant allergic to the following drugs?:  Penicillin  Sulfa Drugs  Tetracycline  Aspirin

Allergy to a medicine, food, plant or insect toxin. Explain \_\_\_\_\_

Asthma  Heart Trouble  Nose Bleeds  Diabetes  Convulsions  Fainting Spells

Any condition that may require special care, diet or restriction of activities for medical reasons.

Explain \_\_\_\_\_

Does participant wear:  Dentures  Contact Lens  Other (Explain) \_\_\_\_\_

Is any medication, including behavior modification medication, being taken at the present time?  Yes  No

If yes, explain \_\_\_\_\_

Date of most recent medical examination: \_\_\_\_\_

Are you aware of any current health problems?  Yes  No If yes, explain \_\_\_\_\_

Is there any accident, illness or past/present history related to the following: (If yes, give dates and full details below.)

|                        | Yes                      | No                       | Year  |                     | Yes                      | No                       | Year  |
|------------------------|--------------------------|--------------------------|-------|---------------------|--------------------------|--------------------------|-------|
| Serious Injury/Illness | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Appendicitis        | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Surgery                | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Kidney Infection    | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Ears, Eyes             | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Back, Joints, Limbs | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Teeth, Tonsils         | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Blood               | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Rheumatic Fever        | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Stomach             | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

| Immunizations           | Last Yr. Given | Immunizations           | Last Yr. Given | Has Had (please check)                |
|-------------------------|----------------|-------------------------|----------------|---------------------------------------|
| Tetanus                 | _____          | Measles                 | _____          | <input type="checkbox"/> Measles      |
| Diphtheria              | _____          | Mumps                   | _____          | <input type="checkbox"/> Mumps        |
| Polio                   | _____          | Rubella                 | _____          | <input type="checkbox"/> Rubella      |
| Hepatitis A, B or C     | _____          | Varicella (chicken pox) | _____          | <input type="checkbox"/> Chicken Pox  |
| <i>(circle one/any)</i> |                |                         |                | <input type="checkbox"/> Tuberculosis |

## E. Consent for First Aid Treatment for \_\_\_\_\_

*(Name of Participant)*

Please complete this Consent for First Aid treatment form. This will allow appropriate treatment for your child in the event of minor illness or injury. Check any or all treatments, **if available**, as your consent. If you do not give us your permission to provide these non-emergency treatments, we will not be able to provide them to your child. Medication may be self-administered under a health care professional's or 4-H agent's supervision as appropriate. Conditions in parentheses are examples of the most frequent use of these medications, but may not be the sole use of the medication.

- Bausch and Lomb® eye wash or generic equivalent (*eye irritation*)
- Benadryl® or generic equivalent (*rash or bee sting*)
- Calamine lotion/Caladryl® or generic equivalent (*sunburn or poison ivy/oak*)
- Emetrol® or generic equivalent (*nausea*)
- Hydrocortisone ointment or other equivalent (*insect bites*)
- Ibuprofen (*pain*)
- Imodium® AD or generic equivalent (*diarrhea*)
- Isodettes® spray or generic equivalent (*sore throat*)
- Lanacane® spray, Solarcaine® or aloe vera gel (*sunburn*)
- Milk of Magnesia®, Mylanta® or generic equivalent (*antacid*)
- Neosporin® or generic equivalent (*topical treatment for cuts*)
- Pepto Bismol® or generic equivalent (*upset stomach*)
- Robitussin® or generic equivalent (*nasal congestion/coughing*)
- Swimmer's ear solution (*earache*)
- Tylenol® or generic equivalent (*pain*)
- Tylenol® cold tablets or generic equivalent (*congestion*)

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## F. Administration of Medication

Check here if your child, \_\_\_\_\_ will have medications and is  
*(Name of Participant)*

competent to self-administer them under appropriate supervision. Medications should be sent to the event or activity in the original pharmacy container and include the following information:

Name of child

Name of medication

Dosage and directions

Name of licensed prescriber (*if applicable*)

Name, address and phone number of pharmacy (*if applicable*)

Prescription number (*if applicable*)

Date prescription was filled (*if applicable*)

**You must attach a photo if you are bringing medication.**

*Photo  
of  
Participant*

## G. Emergency Medical Release

In consideration of \_\_\_\_\_'s (*participant's name*) participation in the 4-H activity or event, I provide the following release. I understand that a health problem or a medical emergency may develop that necessitates the administration of medical care, hospitalization or surgery.

In the event of injury or illness to \_\_\_\_\_ (*participant's name*), I hereby authorize the University of Tennessee and its representative(s) or agent(s) to secure any necessary treatment, including the administration of anesthetics and surgery.

In signing this acceptance form at the bottom of this page, I agree not to hold the University of Tennessee or camp health care professional (or any of its representatives or agents) responsible for any side effects of medications.

I further give permission to the University of Tennessee and its representative(s) or agent(s) to provide the medical history form to healthcare personnel. I authorize any physician, healthcare provider or any hospital to provide reasonable and necessary medical treatment or supplies. This original permission or a photostatic copy thereof is equally valid as an authorization.

I recognize that the event's sickness and accident insurance does not provide full coverage for participants in this activity or event. I accept responsibility for payments of those medical costs incurred for injuries or illnesses that are not covered by the event's insurance.

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### Required Signatures\* - Parent/Guardian and Participant

We have provided accurate information in all areas represented on this form. We understand and agree to the expectations and procedures as stipulated in the preceding sections of this ACTIVITY AND EVENT ACCEPTANCE FORM. We understand that all of the following sections must be initialed to demonstrate our agreement and acceptance and a full, dated signature must be provided at the bottom of this page.

| Parent | & | Participant's Initials |   |
|--------|---|------------------------|---|
| _____  |   | _____                  | <b>A. Identification of Participant</b>     |
| _____  |   | _____                  | <b>B. Code of Conduct</b>                   |
| _____  |   | _____                  | <b>C. Publicity Release</b>                 |
| _____  |   | _____                  | <b>D. Health History and Medical Record</b> |
| _____  |   | _____                  | <b>E. Consent for First Aid Treatment</b>   |
| _____  |   | _____                  | <b>F. Self-Administration of Medication</b> |
| _____  |   | _____                  | <b>G. Emergency Medical Approval</b>        |

*\* If for religious reasons you cannot sign this section, contact your Extension office for a legal waiver (F600C), which must be signed in order to participate.*

**I have read this Release and Assumption of Risk Agreement and sign it on behalf of myself, my heirs, assigns and anyone entitled to act on my behalf.**

Signed \_\_\_\_\_ Date \_\_\_\_\_  
*(Parent or Guardian Signature) (Month/Day/Year)*

Signed \_\_\_\_\_ Date \_\_\_\_\_  
*(Participant Signature) (Month/Day/Year)*

Programs in agriculture and natural resources, 4-H youth development, family and consumer sciences, and resource development.  
University of Tennessee Institute of Agriculture and county governments cooperating.  
UT Extension provides equal opportunities in programs and employment.  
F600-A (revised 12/07) 08-0071