

# 4-H Volunteer Enrollment Form – 2022-2023

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Club \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please Check One:  Female  Male  Prefer Not To State  
 Hispanic  Non-Hispanic  Prefer Not To State  
 I Live On A Farm

Race:  American Indian or Alaskan Native  Asian  Black or African American  Hawaiian or Pacific Islander  Other  White  Prefer Not To State  
 We are a military family. Which branch? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

### HEALTH HISTORY

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

Serious Allergy to Insects:  Yes  No Allergy to Nuts:  Yes  No  
 Allergy to Dairy:  Yes  No Any Other Allergies:  Yes  No  
 Allergy to Gluten:  Yes  No List: \_\_\_\_\_

The following over the counter medications may be administered to my child without contacting me:

Acetaminophen (Tylenol)  Antacid  Antihistamine Pill  Decongestant  Dramamine  
 Hydrocortisone Cream  Ibuprofen (Advil)  Polysporin (topical antibiotic)

Name of Family Doctor \_\_\_\_\_ Doctor's Phone Number \_\_\_\_\_

- |                               | YES                      | NO                       |
|-------------------------------|--------------------------|--------------------------|
| 1) Allergies.....             | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Asthma.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Bronchitis.....            | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Convulsions.....           | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Diabetes.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Ear Infection.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Fainting.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Headaches.....             | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Heart Condition.....       | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Hypoglycemia.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| 11) Other Conditions.....     | <input type="checkbox"/> | <input type="checkbox"/> |
| 12) Any Other Conditions..... | <input type="checkbox"/> | <input type="checkbox"/> |
- List: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Health Insurance

Health Insurance Company \_\_\_\_\_  
 Policy # \_\_\_\_\_  
 Member ID \_\_\_\_\_  
 Name of Policy Holder \_\_\_\_\_  
 Relationship to Participant \_\_\_\_\_  
 List & Explain any restrictions (dietary, physical, etc.)

### MEDICAL TREATMENT

All information provided on this form is correct and complete to the best of my knowledge. This person has permission to engage in all events and activities. I hereby give permission to the event designee to provide routine health care, administer prescription and over the counter medications as noted and see emergency medical treatment if warranted. I agree to the release of all records necessary for medical treatment, billing or insurance. In the event I cannot be reached, I give permission to the attending physician to secure and administer treatment, including hospitalization.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### PUBLICITY RELEASE

I hereby grant the 4-H program, University of Kentucky and their agents, the right to use, reproduce, assign and/or distribute still pictures, video and sound recordings of myself or my minor child without compensation for use in promotion, advertising, educational publications or online content.

SIGNATURE: \_\_\_\_\_  No I do not permit DATE: \_\_\_\_\_

