

4-H Volunteer Enrollment Form – 2024-2025



University of Kentucky
College of Agriculture,
Food and Environment
Cooperative Extension Service



Name: (Last) _____ (First) _____ Club _____ Birthday Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone _____ Email _____

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: _____

For online registration
use the QR code



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: _____

Cooperative
Extension Service

Agriculture and Natural Resources
Family and Consumer Sciences
4-H Youth Development
Community and Economic Development

MARTIN-GATTON COLLEGE OF AGRICULTURE, FOOD AND ENVIRONMENT

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Disabilities
accommodated
with prior notification.