



4-H Youth Development

Cornell Cooperative Extension of Putnam County

Permission Slip and Medical Release Form



Youth's Name:			
Address:			<input type="checkbox"/> Check if your address has changed in the last 6 mos.
Phone:	Email Address:	Date of Birth:	Age:

Emergency Contacts

Parent/Guardian Name:	Relationship:	Phone (day):	(eve):	(Cell):
Parent/Guardian Name:	Relationship:	Phone (day):	(eve):	(Cell):
Neighbor and/or Relative Name:	Relationship:	Phone (day):	(eve):	(Cell):
Neighbor and/or Relative Name:	Relationship:	Phone (day):	(eve):	(Cell):

Medical History (Check any and all that apply to your child:)

Illnesses: <input type="checkbox"/> Asthma <input type="checkbox"/> Convulsions <input type="checkbox"/> Diabetes <input type="checkbox"/> Other (specify) _____ _____	Allergies: <input type="checkbox"/> Hay Fever <input type="checkbox"/> Insect Stings (specify) _____ _____ <input type="checkbox"/> Ivy poisonings	Please list any other health concerns, physical activity restrictions or special dietary needs:
List current prescribed medication:		

Family Medical and Hospitalization Coverage Information

Name of Insurance Company or government program:	Policy Number:
	Phone: Primary Physician:
Primary Dentist:	Phone:

Permission Form (check all you agree to):

- I hereby give my child permission to fully participate (subject to the restrictions noted) in all Cornell Cooperative Extension activities and programs during the _____ 4-H year. I permit the use of any photos, slides, films, digital images, sketches or any other audio visual materials taken of him/her during the activity for publicity, advertising, and promotion.
- I further grant permission to the director, adult volunteer leader, CCE staff or personnel, or other authorized persons to dispense to my child any prescribed medication he/she is currently taking.
- I understand that I will be notified in case of serious injury or illness. However, in the event that I cannot be reached, I hereby give permission for my child named above to be medically treated by a physician or medial facility as appropriate.
- In the event I cannot be reached in an EMERGENCY, I hereby give permission to the Neighbor/Relative listed above to pick up my child or arrange for Emergency medical care. If I or the person(s) listed cannot be reached, EMERGENCY medical care may be given to my child as needed.

Signature of Parent/Guardian: _____ Date: _____

Leader: Keep white copy & Return yellow copy to: Cornell Cooperative Extension, Terravest Corp. Park, 1 Geneva Rd., Brewster, NY 10509