

**PERMISSION FORM FOR  
ADMINISTRATION OF  
MEDICATION  
(PRESCRIPTION & NON-PRESCRIPTION)  
Jefferson County**

Please list child's name and turn in form whether or not any medication is listed. Thank you!

Child's Name: \_\_\_\_\_

1. Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_  
Time to be Administered \_\_\_\_\_  
Purpose of medicine \_\_\_\_\_  
Possible side effects/special instructions \_\_\_\_\_  
\_\_\_\_\_

2. Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_  
Time to be Administered \_\_\_\_\_  
Purpose of medicine \_\_\_\_\_  
Possible side effects/special instructions \_\_\_\_\_  
\_\_\_\_\_

3. Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_  
Time to be Administered \_\_\_\_\_  
Purpose of medicine \_\_\_\_\_  
Possible side effects/special instructions \_\_\_\_\_  
\_\_\_\_\_

Emergency Phone Numbers:

Parent's Name: \_\_\_\_\_ Work \_\_\_\_\_ Home \_\_\_\_\_

Other \_\_\_\_\_ Work \_\_\_\_\_ Home \_\_\_\_\_

**/ ALL MEDICINES (prescription and non-prescription) ARE TO BE TURNED IN UPON CAMP ARRIVAL AND WILL BE KEPT BY THE HEALTH SUPERVISOR AND IN A CENTRALIZED LOCATION.**

I Certify the Necessity of the above Medication (S) and it Is Understood by the Undersigned That There Shall Be No Liability for Civil Damages as a Result of the Administration of Such Medication Where the Person Administering Such Medication Acts as a Reasonably Prudent Person Would Have Acted under the Same or Similar Circumstances.

\_\_\_\_\_

Date

\_\_\_\_\_

Parent/guardians' Signature



# Florida 4-H Participation Form

Youth and Adult



Note: This form must be completed by the participant and/or parent or guardian in order to participate in the 4-H program.  
All items must be completed, even if the response is not applicable – indicate by using N/A.  
This form must be present while traveling to, and during each event.  
Failure to complete this form in its entirety will result in the person being ineligible to participate in 4-H activities.

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_  Youth  Adult  
                   Last                First  Female  Male

Home Address: \_\_\_\_\_ County/District \_\_\_\_\_ / \_\_\_\_\_  
 City, ST Zip: \_\_\_\_\_ Home Phone: ( \_\_\_\_ ) \_\_\_\_\_

Primary Emergency Contact: \_\_\_\_\_ Work Phone: ( \_\_\_\_ ) \_\_\_\_\_  
 Email: \_\_\_\_\_ Cell Phone: ( \_\_\_\_ ) \_\_\_\_\_  
 Alternate Emergency Contact: \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_\_  
 Name of Family Doctor: \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_\_  
 Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
 Name of Insured: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

### HEALTH HISTORY

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

	Yes	No	
1) Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Please explain "Yes" answers and provide information on recent medical issues (including injuries and surgeries), allergic reactions, special dietary regulations, present medications, any specific activities to be restricted and other comments.  _____
2) Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	
3) Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	
4) Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	
5) Ear Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	
6) Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>	
7) Heart Condition.....	<input type="checkbox"/>	<input type="checkbox"/>	
8) Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	
9) Hypoglycemia.....	<input type="checkbox"/>	<input type="checkbox"/>	
10) Serious Insect Stings.....	<input type="checkbox"/>	<input type="checkbox"/>	
11) Wear Glasses.....	<input type="checkbox"/>	<input type="checkbox"/>	
12) Wear Contact Lenses.....	<input type="checkbox"/>	<input type="checkbox"/>	
13) Other Conditions.....	<input type="checkbox"/>	<input type="checkbox"/>	
14) Penicillin Allergy.....	<input type="checkbox"/>	<input type="checkbox"/>	
15) Aspirin Allergy.....	<input type="checkbox"/>	<input type="checkbox"/>	
16) Tetanus Allergy.....	<input type="checkbox"/>	<input type="checkbox"/>	
17) Other Drug Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	
18) Food Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	
19) Serious Ivy, Oak, or Sumac....	<input type="checkbox"/>	<input type="checkbox"/>	
20) Other Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	
21) Other Health Conditions.....	<input type="checkbox"/>	<input type="checkbox"/>	

  

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

<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Antacid	<input type="checkbox"/> Ibuprofen (Advil)
<input type="checkbox"/> Hydrocortisone	<input type="checkbox"/> Decongestant	<input type="checkbox"/> Dramamine
<input type="checkbox"/> Polysporin (topical antibiotics)	<input type="checkbox"/> Acetaminophen (Tylenol)	<input type="checkbox"/> Other

Please contact me for permission to administer ANY over-the-counter medications.

Date of Last Tetanus Shot: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Publicity Release: I authorize UF IFAS Extension and the Florida 4-H Foundation or their assignees to record and photograph my image and/or voice (or that of my child if under 18) for use in research, educational and promotional programs. I also recognize that these audio, video and image recordings are the property of UF IFAS Extension and the Florida 4-H Club Foundation.

No, I do not authorize use of my—or my child’s individual image or voice.

Survey & Evaluation Release: I hereby establish my willingness to participate as an adult (i.e. 4-H leader, other volunteer, parent/ guardian, site manager, etc.) and give permission for my child (under 18 years of age) to complete surveys and evaluations that will be used to determine program effectiveness or to promote the program. I understand that participation in surveys and evaluations is voluntary and that my child and I may choose not to participate and may withdraw from surveys and evaluations without impact on my or my child’s eligibility to participate in the 4-H program. I understand that my child or I may be asked for consent before completing a survey or an evaluation.

No, I am not willing to participate—or give permission for my child to participate—in any program evaluation.

## Florida 4-H Participation Form

### Florida 4-H Code of Conduct for Youth and Adults

As a participant in 4-H at the local, state, or national level, I have the responsibility of representing the UF/IFAS Extension 4-H Youth Development Program to the public. Therefore, I am expected to conduct myself in a manner that will bring honor to me, my family, my community, and 4-H. To do that, I must abide by the following rules:

- (1) Obey local, state, and federal laws. Follow county, district, state and/or national 4-H policies. Abide by any special rules for a 4-H event or activity.
- (2) Speak and act in a responsible, courteous, and respectful way. Harassment, threats or bullying of any type is prohibited.
- (3) Act responsibly to maintain a safe environment for all participants. Acting in a manner that could endanger the health, safety or welfare of yourself or others is prohibited. Report threats to the well-being of any participant immediately to the adult in charge.
- (4) Possession or use of tobacco, alcohol, or illegal drugs is prohibited. Possession or use of approved medications by youth during a 4-H function must be reported to the adult in charge and must not be accessible to other participants.
- (5) Possession or use of weapons or other dangerous objects is prohibited, except when required as part of an approved educational program. Weapons are defined to include, but are not limited to, guns, knives and incendiary or explosive devices of any kind.
- (6) Respect all property, facilities, equipment, and vehicles. I will be responsible for any damage or other consequences resulting from my behavior.
- (7) Participate fully in 4-H functions. Be in the assigned program areas (example—dorms, cabins, programs, etc.) on time. If I am unable to attend or participate, I will tell the adult in charge. Help others have a pleasant experience by making every attempt to include all participants in activities.
- (8) Dress appropriately for each 4-H function.
- (9) Use of any mobile electronic device during a scheduled 4-H activity is prohibited unless activity-specific rules otherwise allow. When permitted, they should be used only in a manner that is consistent with the approved activity and not discourteous or disruptive.
- (10) The belongings of youth participants, including but not limited to bags, purses, computers, other electronic devices, lockers and vehicles, are subject to search and seizure by 4-H faculty/staff, and in some instances a volunteer designee, upon reasonable suspicion that a prohibited and/or illegally possessed substance or object is contained within that area. (If an adult is suspected, this will be handled by law enforcement.)

**Participant Agreement:** Yes  No  I have read the Florida 4-H Code of Conduct above and agree to abide by it in its entirety. I realize my failure to do so could result in a loss of privileges during a 4-H event and in the future; including but not limited to suspension or termination of 4-H membership or volunteer service.

#### Parent/Guardian or Adult Participant Code of Conduct Verification:

Yes  No  I understand and agree to the Florida 4-H Code of Conduct above—considered a Parent/ Guardian or Adult Participant Signature.

**Medical Release:** I understand participants will be supervised and that, if serious illness or injury develops, medical and/or hospital care will be given. I hereby give my permission to the attending physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child, or myself and affirm that the information set forth in the Health History is true and correct to the best of my knowledge and belief. I realize the event's insurance will cover only a portion of the medical costs and I, or my personal insurance, may be responsible for the remaining expenses. You must complete the medical information on the front of this sheet.

Yes  No  I understand & Agree to the Medical Release, considered a Parent/Guardian or Adult Participant Signature.

**General Release:** I hereby release the University of Florida/IFAS Extension 4-H Youth Development Program at the state, district, and local levels, the Florida 4-H Club Foundation, Inc., the State of Florida, and their agents, trustees, officers and employees, from all claims, demands and causes of actions of any kind, including the claims of negligence, which may arise from participation of myself or my minor child in any Florida 4-H sponsored activity, and this release is specifically granted in consideration of the services, programs and activities being provided by Florida 4-H.

Yes  No  I understand and agree to the General Release—considered a Parent/Adult or Adult Participant Signature.

**Member Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Revised April 2013