University of California
Agriculture and Natural Resources ▮ 4-H Youth Development Program

# Youth Treatment Authorization Form

(PAGE SUBMITTED TO AND RETAINED BY THE 4-H CLUB/UNIT LEADER)

This Treatment Authorization Form is authorized for all 4-H Youth Development meetings and activities during the dates specified below. (Please Note: This information must be updated annually)

First Name Last Name

Club/Unit Name

County and State

From: **July 1, 2016** to **December 31, 2017**

**EMERGENCY CONTACT INFORMATION**:

First & Last Name: _____ Home/Work/Other Phone: _____

Relationship: _____ Cell Phone: _____

While my child is attending or traveling to or from this 4-H function, I HEREBY AUTHORIZE THE 4-H ADULT VOLUNTEER OR 4-H STAFF MEMBER, or in his/her absence or disability, any adult accompanying or assisting him/her, TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR SAID MINOR:

Any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code Section 2000 et seq.; or any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code Section 1600 et seq.

This authorization is given pursuant to the provisions of California Family Code Section 6910. This authorization shall remain effective until my child completes his/her activities in this program unless sooner revoked in writing. I understand that as a parent/guardian, I will be responsible for the cost of any service or treatment provided not covered by the 4-H Accident/Sickness Insurance Program sponsored by UC Cooperative Extension.

**AUTHORIZATION AND CONSENT AND RELEASE**

I hereby certify that my child is in good health and can travel to and participate in all functions of the 4-H Youth Development Program as described above. I am the parent/guardian having legal custody of the youth member named above as stated under California Family Code Section 6550. I understand it is my responsibility to keep the information on this form updated (including Health History) by contacting the County 4-H Office.

_____

Signature of Parent/Guardian Date

**NON-CONSENT**

I do not desire to sign this authorization and understand that this will prohibit my child from receiving any non-life threatening medical attention in the event of illness or accident.

_____

Signature of Parent/Guardian Date

University policy and the State of California Information Practices Act of 1977 require the following information be provided when collecting personal information from you: The information entered on this form is collected under authority of the Smith-Lever Act. Submission of the medical data is voluntary. However, a signature is required on one or the other of the two signature lines above. Failure to provide the medical information and authorization may result in our inability to provide necessary medical treatment. You have the right to review University records containing personal information about you, with certain exceptions as set forth in policy and statute. Copies of University policies pertaining to the collection, use, or release of personal data are available for your examination from the local UCCE County Director, 4-H Youth Development Advisor, 4-H Program Representative or the Associate Director of 4-H Program & Policy at University of California, Division of Agriculture and Natural Resources, California State 4-H Office, 2801 Second Street, Davis, CA 95618-7774, (530) 750-1334, ca4h@ucanr.edu. Only your own records are open to your review.

*Form Revised 7/1/2016*

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## Health History Information

(PAGE SUBMITTED TO AND RETAINED BY THE 4-H CLUB/UNIT LEADER; SHRED AFTER THE PROGRAM YEAR)
(please attach extra page if more space is needed)

First Name | Last Name | County | Date of Birth

Date of last Tetanus Vaccination: ☐ Not Sure ☐ None

Please check over-the-counter medications that may be administered:
☐ Tylenol ☐ Ibuprofen ☐ Cough Syrup ☐ Decongestant ☐ Dramamine ☐ Antacid ☐ Polysporin

☐ Hydrocortisone ☐ Benadryl ☐ Other:

Please identify if this participant has any health conditions that are important for program staff to know in order to maximize participation and ensure safety and well-being?:

☐ Or check this box if no information needs to be shared

Please list all current medications:

| Name of Medication | Dosage | Times Taken |
|---|---|---|
| | | |
| | | |
| | | |

Please identify any allergies including allergies to food, medications, and drug reactions:

Please include any additional remarks and special instructions to better assist emergency service personnel.

Please list any additional assistance the youth will need in order to participate in this program or activity.
Note: in some cases, a Doctor's note may be required to confirm the request.

| | Yes | No |
|---|---|---|
| Does the youth have any current emotional or behavioral difficulties that would be helpful for us to know about? | | |
| Are there any ways of responding to the youth's negative moods or feelings that you found to be effective? | | |
| Would you like to share any significant life or family events that will help us support the youth's current emotional state? | | |

Please explain any "Yes" answers on this page.

*Form Revised 7/1/2016*