University of California Division of Agriculture and Natural Resources
4-H Youth Development Program
Adult Volunteer Treatment Authorization Form

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

Pincrest, CA | Feb. 14, 2014 to Feb. 17, 2014

County and State | Dates (From / To)

While I am attending or traveling to or from this 4-H function, I HEREBY AUTHORIZE THE ADULT 4-H 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 ME SHOULD I BE UNABLE TO MAKE A DECISION:

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 Section 25.8 of the Civil Code of California. This authorization shall remain effective until I complete my activities in this program unless sooner revoked in writing. I understand that 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.

EMERGENCY CONTACT INFORMATION

Name | Relationship to Adult Identified Above

( ) | ( )
Emergency Day Phone (with area code) | Emergency Night Phone (with area code)

Mailing Address | City | State | Zip

AUTHORIZATION AND CONSENT AND RELEASE

I hereby certify that I am in good health and can travel to and participate in all functions of the 4-H Youth Development Program as described above. I understand is it my responsibility to keep the information on this form updated (including Health History) by contacting the County 4-H Office.

_____ | Date
Signature

NON-CONSENT

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

_____ | Date
Signature

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 of the California 4-H Youth Development Program, University of California, DANR Building, One Shields Ave., Davis, CA 95616-8575, (530) 754-8518. Only your own records are open to your review.
Any known or foreseeable intergovernmental transfer that may be made of the information is as follows: None.

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

Health History Information

First Name | Last Name | County | Date of Birth

Subject to:	YES	No	Now Have or Have Had	Yes	No
Colds			Heart Trouble		
Sore Throat			Asthma		
Fainting Spells			Lung Trouble		
Bronchitis			Sinus Trouble		
Convulsions			Hernia (rupture)		
Cramps			Appendicitis		
Allergies			Has appendix been removed?		
Wear corrective lenses?			Do you walk in your sleep?		
Is hearing good?					

Date of last Tetanus Vaccination:

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

Please list any disability accommodations you will need in order to participate in this program or activity.

Please list all current medications:

Name of Medication	Dosage	Times Taken

Please include any additional remarks and special instructions to better assist emergency service personnel.
Please explain "yes" answers on this page.

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