

**PLEASE NOTE:** Do not return this to the 4-H office.  
It is meant for the club leader to have on hand for  
any club meetings or activities.

Code 1501  
Attachment IV  
5/99

Cornell Cooperative Extension  
Permission Slip and Medical Release Form

Please print:

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

In case of emergency, contact \_\_\_\_\_ Phone \_\_\_\_\_

Activity \_\_\_\_\_ Date(s) \_\_\_\_\_ Location(s) \_\_\_\_\_

Activity Director \_\_\_\_\_

**Medical History**

Check any and all that apply to your child:

Date of Last Tetanus Booster \_\_\_\_\_

Illnesses

Allergies

Ear Infections \_\_\_\_\_

Hay Fever \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_

Insect Stings \_\_\_\_\_

Convulsions \_\_\_\_\_

Ivy Poisonings \_\_\_\_\_

Diabetes \_\_\_\_\_

Penicillin \_\_\_\_\_

Other (specify) \_\_\_\_\_ Other (specify) \_\_\_\_\_

Current prescribed medication (specify) \_\_\_\_\_

On the back of this form, specify any other health concerns, physical activity restrictions, or other information you want the chaperons or director of this activity to be aware of on behalf of your child's welfare. Also indicate if your child requires any special dietary needs.

**Family Medical and Hospitalization Coverage**

Name of Insurance Company or Government Program \_\_\_\_\_

Identification/Policy # \_\_\_\_\_

Family Physician's Name and Phone Number \_\_\_\_\_

I hereby give my child permission to fully participate (subject to the restrictions noted) in the Cornell Cooperative Extension activity on the date(s) and at the location(s) indicated above. I permit the use of any photos, slides, films, or sketches of him/her taken during the activity for publicity, advertising, and promotion.

I further grant permission to the director of the activity (or authorized designee) 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 medical facility as appropriate.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian