

WASHINGTON 4-H ENROLLMENT FORM

(Office Use Only)

County Code: 0 34
(0+2-digit-WA county number)

Group Code:
(3-digit club/group number)

Member Code:
(5-digit unique member/leader ID#)

(Leader fills in this section)

DATE: _____ GEN/ORG. LEADER: _____ PHONE: () _____

CLUB NAME: _____ MAILING ADDRESS: _____

Circle one: 1-Community Club 2-Sch. Club 3-After-Sch. Club 4-Military Club 5-Spec. Int./Short-Term
6-Overnight Camp 7-Day Camp 8-Sch. Enrichment 9-Individual/Fam. 4-H 10-Sch. Age Care

PLEASE PRINT

Circle one: M-Member G-General/Org. Ldr. P-Project Ldr. A-Activity Ldr. R-Resource Ldr.

Circle one: N-New Enrollment R-Re-enrollment D-Drop from Club Ch-Change/Add Information

Youth Leader Circle one or more: Indirect Volunteer Direct Volunteer Middle Manager
(Members Only) (Youth Leaders or Adult Leaders Only)

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____

Zip + 4: _____ - _____ City: _____ State: _____

School (Opt.): _____ Yr. in 4-H: _____ Birthday: ____ / ____ / ____ Gender: M F

Grade: _____ (Yth. only) Disabled: Disability: _____ Accommodation Needed? Yes No

Residence: Farm Rural Urban Suburb Central City E-mail _____
 (Under 10,000) (Under 50,000) (Over 50,000) (Over 50,000)

Ethnic: Hispanic Not Hispanic

Race: (Check all that apply) White Black Alaskan/Am.Indian Asian Hawaiian/Pac.Isl. Other

PROJECT CODE	PROJECT NAME	PROJECT YEAR
Example: FHB	Just Outside the Door	1
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Guardian: _____ Signature: _____

Home Ph: _____ - _____ - _____ Work: _____ - _____ - _____ Family E-mail _____

Leader Signature: _____ Date: _____

Note to 4-H club leader: this form to be returned to WSU Thurston county Extension Office

**WASHINGTON STATE UNIVERSITY (WSU)
4-H CLUB ACTIVITIES**

**For Parents or Guardians of Participants Under 18 Years of Age
For the 4-H Club Year of October 1, 2011 to September 30, 2012**

ASSUMPTION OF RISK

I understand that there are risks in participating in 4-H club member activities which include attending club meetings, hands-on project work, fundraisers, community service, preparing for and participating in county fair qualifiers, spring fairs, county fair, and state fair at the Thurston County 4-H Club activities of Washington State University (WSU).

In consideration for and as a condition of being allowed to participate in this voluntary activity, I agree to take full responsibility for any and all risks that exist, including the risk of death or injury to my child or loss or damage to my property. I understand that there may be risks that WSU cannot predict or foresee, and I also assume full responsibility for those risks.

Risks in participating in the 4-H Club activities (attending club meetings, hands-on project work, fundraisers, community service, preparing for and participating in county fair qualifiers, spring fairs, county fair, and state fair), include, but are not limited to: temporary or permanent muscle soreness, sprains, strains, cuts, abrasions, bruises, ligament and/or cartilage damage, orthopedic damage, head, neck or spinal injuries, loss or use of arms and/or legs, eye damage, disfigurement, burns, drowning or death. I also recognize that there are both foreseeable and unforeseeable risks of injury or death that may occur as a result of traveling to or from the 4-H Club activities that cannot be specifically listed. Further, I recognize that the actions of other participants in the activity may cause harm or loss to my child or property.

RELEASE OF LIABILITY

I release, the state of Washington, the Regents of WSU, WSU, any subdivision or unit of WSU, its officers, employees, and agents, from any and all liability, claims, costs, expenses, injuries and/or losses to person or property, which I may sustain and/or sustain as a result of death or injury of my child, as a result of or connected with participation in the above event. My child's participation includes, but is not limited to, travel to and from the event in a private or public vehicle, any activity connected with the event itself, and use of state equipment or facilities for the event whether on or off WSU property. **I have carefully read this document, understand its contents and am fully informed about this program and circumstances. I am aware that this document is a contract with WSU and the program sponsors. I sign it freely and voluntarily.**

DATED THIS DAY of ,

Name of Parent or Guardian (Printed)

Signature

Name of Minor (Printed):

Note to 4-H Club Leader: This form to be returned to the WSU Thurston County 4-H Office

Image and Voice Recordings Consent

_____ (print student's name) and his/her parent or guardian, hereby grant permission to Washington State University (WSU) to be photographed or otherwise have images or voice recordings made (including but not limited to digital photographs, video or digital moving images and/or voice recordings), for WSU publication or promotional purposes in any medium (including but not limited to print media, newspaper, television, video, motion picture, or Web site on the Internet).

I additionally consent to the use of the student's name and/or interview comments in connection with WSU publication or promotional purposes in print media, newspaper, television, video, motion picture, or Web site on the Internet.

We understand that consent to use of the student participant's likeness or voice recordings is not a condition of participating in the activity and that consent can be refused without any impact in the ability to fully participate in the program.

No inducements or promises beyond our acceptance of an opportunity to promote WSU and its programs have been given to the persons signing below.

Any other use of images and/or recordings, my name, and/or interview comments requires advance permission.

We understand that we can revoke this consent at any time upon notice to WSU, at which time either or both of us will sign a copy of the denial (below) for use of images or voice recordings.

We agree to use of digital images or voice recordings as set forth above:

Signature of Parent/Guardian (for participant less than 18 years of age)

Date

Signature of Participant

Date

We do not agree to use of digital images or voice recordings as set forth above:

Signature of Parent/Guardian (for participant less than 18 years of age)

Date

Signature of Participant

Date

Note to 4-H Club Leader: This form to be retained and filed confidentially with your 4-H Club Leader Files

**Washington State University
Thurston County 4-H Club Participation
Emergency Medical Release
For the 4-H Year of October 1, 2011-September 30, 2012**

In an emergency requiring medical attention or a situation reasonably believed by Washington State University (WSU) authorized agents including *Thurston County 4-H Club* staff to be an emergency; I authorize WSU and its authorized agents to obtain emergency medical care for my child. I will be responsible for any expenses incurred in so doing including but not limited to care by health care professionals, hospital care, and ambulance or other services. In addition, the health care provider has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

NOTE: Minors may consent to certain services in Washington.

I hold harmless and agree to indemnify Washington State University, its authorized agents and employees and the staff of the *Thurston County 4-H Club* from decisions to seek emergency treatment.

Please complete the following:

Student Participant: _____

Date of Birth: _____

Parent or Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ E-mail: _____

Health-Care Providers:

Name of participant's primary doctor(s): _____ Phone: (____) _____

Name of dentist(s): _____ Phone: (____) _____

Name of orthodontist(s): _____ Phone: (____) _____

Additional health care provider(s) name(s) and contact numbers:

Medical Insurance Information:

This participant is covered by family medical and/or hospital insurance Yes No

Primary Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number (____) _____

Secondary Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number (____) _____

Name of another person to contact in case of emergency if you are not available:

Phone: (____) _____ E-mail: _____

Relationship to participant: _____

I voluntarily sign this authorization in consideration for permission for my child to participate in *Thurston County 4-H Club activities*. I have read it, and I understand its content and significance.

Signature of Parent/Guardian
(For participant less than 18 years of age)

Date

Signature of Participant
(For participant 18 years of age or older)

Date

Note to 4-H Club Leader: This form to be retained and filed confidentially with 4-H Club Leader Files

Thurston County 4-H Club
Program
PARTICIPANT HEALTHFORM

Page 1/2

Mail this form to the address below by _____ (date)
4-H Club Leader Address:

Attendance dates: from: October 1, 2011 to September 30, 2012

Participant Name: _____
First Middle Last

Male Female Birth Date _____ Age on arrival at program _____
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1. Complete pages 1 and 2 of this form (and make a copy for yourself).
2. Send the original, signed form to program by requested date.

Participant Name: _____
First Middle Last
 (For Camp Use) Cabin or Group _____
 (For Program Use) Session Code(s) _____

Participant Home Address: _____
Street Address City State Zip Code

Parent/guardian with residential placement and/or decision-making authority in the event of illness or injury:

Name: _____ Relationship to Participant: _____
 Preferred Phones: (____) _____ (____) _____ Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Participant: _____
 Preferred Phones: (____) _____ (____) _____ Email: _____

Additional parent/guardian to be contacted in case of illness or injury:

Name: _____ Relationship to Participant: _____
 Preferred Phones: (____) _____ (____) _____ Email: _____

Allergies: No known allergies. This participant is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
 (Please describe below what the participant is allergic to and the reaction seen, in detail. Please describe preventative or responsive measures.)
 This participant has a life-threatening allergy. An emergency care plan signed by physician is required.

Diet, Nutrition: This participant eats a regular diet. This participant eats a vegetarian diet (describe details below).
 This participant has special food needs. (Please describe below.)

Immunizations:

My child is up-to-date on his/her immunizations and tetanus shots as required by Washington State law.

My child has an immunization exemption on file with his/her school. I understand and accept the risks to my child from not being fully immunized.

Medication:

We will be unable to administer medication to children. If your child requires a dosage during activity/event hours, please make appropriate arrangements. Medication is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **All medications must be in their original containers. Prescriptions must have the child's name and how the medication should be given printed on the prescription container. Please send only those medications that are necessary.**

Medications Currently being taken: (must list)

This participant will not take any daily medications while attending the activities.

This participant will be self-administering the following daily medication(s) while attending the activities.¹

¹ Note: These provisions regarding administration of medication shall not abrogate minors' rights to provide their own consent to certain services under Washington law.

Note to 4-H Club Leader: This form to be retained and filed confidentially with 4-H Club Leader Files

*Thurston County 4-H Club
Program*
PARTICIPANT HEALTH FORM

PAGE 2/2

Participant Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does this participant:

- | | | | |
|--|--|---|--|
| 1. Ever been hospitalized?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Ever had back/joint problems?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with diarrhea/constipation?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Have any skin problems?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Has asthma/wheezing/shortness of breath?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Traveled outside the country in the past 9 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Had Sickle Cell disease or traits?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Had high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Had cardiovascular disease or other heart problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Have a history of heart disease (not limited to conjunctive heart defect, cardiomyopathy, abrythemia?)..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Had fainting or dizziness?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

- Restrictions:**
- I have reviewed the program and activities of the program and feel the participant can participate without restrictions.
 - I have reviewed the program and activities of the program and feel the participant can participate with the following restrictions or adaptations. *(Please describe below.)*

Does the participant require reasonable accommodation for a disability in order to access or be part of the activities?

What Have We Forgotten to Ask? Please provide in the space below any additional information about the participant's health that you think important or that may affect his or her ability to fully participate in the program. **Attach additional information if needed.**

This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all program activities except as set forth by me and/or an examining physician. If you fail to advise WSU of a medical condition, WSU is not responsible for related injuries. I understand the information on this form will be shared on a "need to know" basis with WSU staff and volunteers. I give permission to photocopy this form. In addition, the health care provider has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial _____ Relationship to Participant: _____

Parent/Guardian: _____ Date: _____

Parent/Guardians: Keep a copy for your records.