



# Bay County Florida 4-H Participation Form 2009-2010



**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 (for example: no health insurance).**  
 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 Month / Day / Year  Female  Male

**Club** \_\_\_\_\_ **School** \_\_\_\_\_ **Grade** \_\_\_\_\_ **Year in 4-H** \_\_\_\_\_

**Category** (Circle one): Member Cloverbud (Age 5-7) Volunteer Special **Enrollment type:** New Reenroll Club change Drop

**Ethnic** (Circle one): Hispanic Non-Hispanic **Race:** (Circle all that apply) White Black Alaskan/Am Indian Asian Hawaiian/Pac Island

Home Address \_\_\_\_\_ County / District \_\_\_\_\_ / \_\_\_\_\_

City \_\_\_\_\_ FL \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Primary Emergency Contact \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Alternate Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Military  A member of my family is in the military, guard or reserves. Relationship to Participant: \_\_\_\_\_  
 If yes, please indicate the branch of service. Check **all** boxes that apply.

Family  Air Force  Army  Coast Guard  Navy  Marine Corps  National Guard  Reserves  Retired

Name of Family Doctor \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Policy number \_\_\_\_\_

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.

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.

|                                | Yes                      | No                       |       |
|--------------------------------|--------------------------|--------------------------|-------|
| 1) Asthma                      | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 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"/> | _____ |

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

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

Antihistamine  Antacid  Ibuprofen (Advil)  Acetaminophen (Tylenol)  
 Decongestant  Dramamine  Hydrocortisone  Polysporin (topical antibiotics)  
 Other \_\_\_\_\_  Please contact me for permission to administer ANY over-the-counter medications

## 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/or the Florida 4-H 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 or 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 EVENTS – YOUTH/ADULT CODE OF CONDUCT

As a participant in Florida 4-H Events, you have the responsibility of representing Florida 4-H programs to the public. You are expected to conduct yourself in a manner that will bring honor to you, your family and 4-H. To do that, you must:

- 1) Be in the assigned program area (for example: dorms, cabins, programs, etc.) at all times. If you are unable to attend, please tell the adult in charge.
- 2) Follow hours and room rules established before the event begins. You are responsible to know the rules for each event.
- 3) Dress appropriately for each event.
- 4) Be responsible to know and use language and manners appropriate for Florida 4-H.
- 5) Act responsibly to maintain a safe environment for all participants.
- 6) Know that the use of tobacco, alcohol and non-prescribed drugs is illegal and prohibited at all 4-H events.
- 7) Model respect for other persons, facilities and vehicles. You will be personally responsible for any damage caused as a result of your behavior.
- 8) Help others have a pleasant experience by making every attempt to include all participants in activities.
- 9) Know that harassment of any type is illegal and prohibited at all 4-H events.
- 10) Not use a cell phone during any scheduled events. You understand that abuse of this could lead to loss of cell phone privileges or confiscation of your phone.

**PARTICIPANT:** *I have read the Florida 4-H Events Code of Conduct above and agree to live up to the expectations. I realize my failure to do so could result in a loss of privileges during the event and/or in the future.*

**Participant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

### VERIFICATION

I, \_\_\_\_\_ (parent/guardian or adult participant) 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.

**Parent/Guardian or Adult Participant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I have read and understand the Florida 4-H Events Youth/Adult Code of Conduct, Publicity Release and Survey & Evaluation Release.

**Parent/Guardian or Adult Participant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I hereby release the Florida 4-H Foundation, local extension boards, the University of Florida, the State of Florida, and their agents, trustees, officers and employees, from all claims, demands, and causes of action of any kind, including 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.

**Parent/Guardian or Adult Participant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# Directions for Florida 4-H Participation Form

This form is to be completed at least once per year for all 4-H members. Adults are required to use this form for state events and activities. All participants should review and update their forms before each major event or activity. Below are a few explanations for sections or spaces where questions are anticipated.

**Date of Birth and Age:** Optional for adults.

**Primary Emergency Contact:** Parent or Guardian of youth; Spouse, or other contact for adults.

**County/District:** Where participant is enrolled or registered for 4-H; not necessarily the county where they live.

**Home Address:** Participant's primary mailing address.

**E-mail:** Optional, but useful for activity coordinators

**Alternate Emergency Contact:** Someone other than the Primary Emergency Contact. Please include their phone number to the right of their name.

**Military Family:** Please indicate if you are a military family and the branch of service.

**Family Doctor:** Please include the doctor's phone number to the right of their name.

**Name of Insured:** List the individual who the insurance is provided through. Relationship could be: self, father, mother, spouse, etc.

**Health History:** This section is important to help the activity coordinators and health care providers be aware of serious or special medical issues and diagnose problems. It is the parents' or participants' responsibility to keep this and other sections current. Please use the blank/lined section to provide details on any serious conditions that need explanation.

**Be sure to include any medications the participant is currently using.**

**Publicity Release:** Only needs to be checked if the participant refuses to allow their voice or image to be recorded.

**Survey and Evaluation Release:** This preliminary permission only needs to be checked if the participant refuses to be involved in any program evaluation.

**Youth/Adult Code of Conduct:** All participants (regardless of age) must read and sign this section. Adults are included in this section for the purpose of maintaining effective role models and chaperones.

**Verification:** Must be signed by adult participants, parents, or guardians. Youth participants 18 years and older may sign, but a parent or guardian signature is preferred.