Name of 4-H Activity_____ **Date(s)**_____

4-H Program Participation Permission, Agreements, and Health Form

Participant: *Please read this form carefully, provide all requested information, and sign and date the bottom of this page.*

Name:_____
last, first, middle initial

Mailing Address:_____

Town, State, Zip:_____

Telephone:(_____)_____County_____

Birth Date: (M/D/Y)_____ Circle one: Male Female

Roommate preference (if applicable to this event) _____, _____

As a participant in this program, I understand that I represent myself; my family; my county; Maine; and all Maine 4-H participants, volunteers and staff. By my actions, will 4-H be judged. Therefore, by my signature below, I agree to:

1. Participate fully in this program.
2. Follow all schedule times including curfew and wake-up hours; to be where assigned, when assigned.
3. Follow the Dress code established for this program/event.
4. Uphold the highest standards of behavior, manners and language.
5. Refrain from using alcoholic beverages, non-prescribed or illegal drugs, tobacco products, or fireworks.
6. Respect the rights of others at all times and make every attempt to include all participants in all activities.
7. Leave the facilities in the same condition or better than I found them when I arrived.
8. Support and follow all leadership and direction received from coordinators, chaperones and any other adult authority.
9. Respect the personal space and property of others in all settings including during overnight programs.
10. Seek assistance and support from adult chaperones on behalf of myself or others should a situation arise that warrants adult intervention or makes me feel uncomfortable.

I understand that if I break this agreement, I must accept the consequences of my actions, which might include a loss of privileges during this program, loss of 4-H privileges in the future, and/or immediate dismissal from this program as determined by county and/or state 4-H staff.

Signature:_____Date:_____

Parent/Guardian: *Please read both sides/pages of this form carefully, provide all requested information, and sign and date where requested.*

Name of 4-H Member_____

Name of 4-H Activity_____ **Date(s)**_____

Parental Statement

My son/daughter/ward has my permission to attend this program. Should my son/daughter/ward require medical attention while attending this program, I hereby give my consent for physicians to provide necessary medical treatment and will pay for same. I consider my son/daughter/ward's health to be POOR___, FAIR___, GOOD___, EXCELLENT___. I am not aware of any physical, mental or communicable conditions that will interfere with participation in this program which have not already been discussed with the event Coordinator.

I agree to indemnify, hold harmless and release the University, its Trustees, faculty, employees, volunteers and agents, from and against any and all claims, demands, actions or causes of action, on account of damage or loss to my personal property, my personal injury or death, or the bodily injury, death or damage to personal property of others caused by me, which may occur or result directly or indirectly from my participation in the Program and not as a direct result of any negligent act of the University, its Trustees, faculty, employees, volunteers or agents.

Furthermore, I have read and understand the statements my son/daughter/ward has agreed to above and support this agreement. I realize that I am personally responsible for my son/daughter/ward while he/she is attending this program. I understand and expect that should my son/daughter/ward break this agreement and the adult coordinators find it necessary to dismiss him/her from this program, that I am responsible for his/her transportation home.

Signature:_____Date:_____

Print Name:_____
Relationship to participant:: circle one Parent Guardian Other_____

Telephone: day_(_____)_____evening__(_____)_____

Please indicate where parent/guardian can be reached during this function/if applicable and provide contact information: _____

Mailing Address if different from participant's:_____

Participant Health Information

Family Physician_____Telephone_(_____)_____

Insurance Company_____Policy Number_____

Date of last Tetanus shot_____

PLEASE ANSWER THE FOLLOWING QUESTIONS: (explain all "yes" answers)

Respiratory Problems(Asthma, blood spitting, persistent cough, abnormal chest X-ray, T.B., etc.) ..... Y/N
Heart Disease(High or low blood pressure, shortness of breath, murmurs, chest pain, Rheumatic Fever) ..... Y/N
Stomach or intestinal problems (Ulcers, jaundice, hernia, colitis, indigestion, etc) ..... Y/N
Kidney, Gall Bladder, or Liver Disease ..... Y/N
Diabetes or Hypoglycemia (low Blood Sugar) ..... Y/N
Muscular/Skeletal Problems (Arthritis, hernia, recent fractures, etc.) ..... Y/N
Eye, ear, nose, or throat problems (hay fever, ear infection, impaired sight or hearing) ..... Y/N
Skin diseases ..... Y/N
Dizziness, etc. ..... Y/N
Emotional or mental disorders (Frequent anxiety, excessive fears, etc.) ..... Y/N
Surgical Operations, accident or injuries, which required hospitalization in the past 2 years ..... Y/N
Recent exposure to a Contagious Disease ..... Y/N
Allergies ..... Y/N
Are you currently under a doctor's care? ..... Y/N
Are you currently taking medication? ..... Y/N
Do you have any special dietary needs? ..... Y/N
Do you have any limiting physical conditions? ..... Y/N

Explanation