UNIVERSITY OF CALIFORNIA
Agriculture and Natural Resources | 4-H Youth Development Program

Adult Volunteer Treatment Authorization Form - Print all information clearly.

(PAGE SUBMITTED TO AND RETAINED BY THE 4-H CLUB/UNIT LEADER)

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 _____

County and State _____ From: **July 1, 2020** to **December 31, 2021**

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 California Family Code Section 6910. 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:

First & Last Name: _____ Home/work/other Phone: _____

Relationship: _____ Cell Phone: _____

_____ _____

Signature Date

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.

_____ _____

Signature Date

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 Statewide 4-H Director at University of California, Division of Agriculture and Natural Resources, California State 4-H Office, 2801 Second Street, Davis, CA 95618-7774, (530) 750-1334, ca4h@ucanr.edu. Only your own records are open to your review.

Health History Information - Print all information clearly.

(PAGE SUBMITTED TO AND RETAINED BY THE 4-H CLUB/UNIT LEADER; SHRED AFTER THE PROGRAM YEAR)

First Name | Last Name | County | Date of Birth

Date of last Tetanus Vaccination: _____ ☐ Not Sure ☐ None

Please check which over-the-counter medications that may be administered: (if available)

☐ Pain/fever reliever (ex. Tylenol) ☐ Ibuprofen (ex. Advil) ☐ Cough Suppressant
☐ Motion sickness/nausea medication ☐ Allergy medication (Benadryl ☐ Decongestant
☐ Antacid ☐ Antibiotic ointment ☐ Anti-Itch Cream

☐ Other: _____

Please identify if you have any health conditions that are important for program staff to know in order to maximize participation and ensure safety and well-being:

☐ Or check this box if no information needs to be shared

Please list all current medications:

Name of Medication	Dosage	Times Taken

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

Please include any additional remarks and special instructions to better assist emergency service personnel.

If additional space is needed to answer any questions above, please use the space below to include information.