University of Idaho 4-H Shooting Sports Program

Adult Medical Emergency Information

(for those not certified as 4-H volunteers)

Name: (First) _____ (Last) _____ (Middle Initial) _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

EMERGENCY CONTACTS:

In case you are incapacitated, name of two adults who may be contacted

1. Name: _____ Relationship: _____ Phone (____) _____

2. Name: _____ Relationship: _____ Phone (____) _____

Name of family physician: _____ Phone (____) _____

Health Insurance Provider: _____

Policy Number: _____ Policyholder's Name: _____

GENERAL HEALTH & MEDICAL HISTORY:

Provide a response for all questions. If condition does not apply, mark "N/A"

1. Year of last immunization or booster for Tetanus Toxoid _____ (must list date)

2. Any operations, serious injuries or chronic illness (please specify): _____

   _____

3. Any allergies (please specify): _____

4. Any other conditions which we should be aware of? _____

   _____

MEDICAL RELEASE:

I have completed the above information and will assume the responsibility for restricting any activities necessary. I will exercise good judgement in regard to my own health, safety and well-being while participating in this program.

I verify that the above medical information is complete and accurate. I also understand that reasonable measures will be taken to safeguard the health and safety of all participants and that my contacts will be notified as soon as possible in case of any emergency affecting me. In the event of an emergency, I hereby authorize the engagement of any medical service providers, at my expense, to provide whatever emergency medical or surgical treatment is necessary.

Signed (Adult Participant) _____ Date _____