COOPERATIVE EXTENSION
COLLEGE OF AGRICULTURE
TENNESSEE STATE UNIVERSITY

Photo of Participant

4-H YOUTH DEVELOPMENT
UT EXTENSION
INSTITUTE OF AGRICULTURE
THE UNIVERSITY OF TENNESSEE

F600-B

Name ______________________________ **County** ______________

ADULT ACTIVITY AND EVENT ACCEPTANCE FORM

Volunteer or Paid Staff Member

This form is valid for one calendar year (beginning on January 1st of the current year) and will expire on December 31st of the current year. Any updates to this information are required to be submitted in writing to the county extension office no later than 7 days prior to the next 4-H event.

The purpose of this form is to give you an opportunity to provide information concerning your health in case of an emergency. You must complete sections I, II and IV. Section III is optional. If under age 18, you should complete Form 600-A.

I. IDENTIFICATION

Name ______________________________ Home Phone ( ) ____________
Last First Middle

Date of Birth ______________________ Sex ☐ Male ☐ Female

Home Address ____
Street/P.O. Box City State ZIP

Emergency Contact ____
Name

Address ______________________________ Home Phone ( ) ____________
Street/P.O. Box City State ZIP

Relationship ______________________________ Work Phone ( ) ____________

II. PUBLICITY RELEASE

As indicated by the signature below, I authorize the University of Tennessee, Tennessee State University, and the Tennessee 4-H Foundation to photograph, film, audio/video record and/or televise my image and voice, and biographical material, in whole or in part in any medium now known or developed in the future, without any restrictions.

Signature ______________________________ Date ____________

Date received in 4-H Center or county office ______________________

Name ______________________________ **County** ______________

III. HEALTH HISTORY AND MEDICAL RECORD

The information on this form will be provided to any health care providers in case of an emergency. This information will not be used to discriminate against a participant on the basis of any disability.

Name of Physician ______________________ Phone ( ) ______

Medical/Hospital ______________________

Carrier Policy of Group #

CHECK ALL THAT APPLY

☐ Allergy to a medicine, food, plant, or insect toxin. Explain ______________________

Is participant allergic to the following drugs: ☐ Penicillin ☐ Sulfa Drugs ☐ Tetracycline ☐ Aspirin

List allergies to other drugs or allergens ______________________

☐ Any condition that may require special care, diet or restriction of activities for medical reasons. Explain ______________________

☐ Asthma ☐ Heart Trouble ☐ Nosebleeds ☐ Diabetes ☐ Convulsions ☐ Fainting Spells

Do you wear? ☐ Dentures ☐ Contact Lens ☐ Other (Explain) ______________________

Is any medication, including medication for behavior modification, being taken at the present time? ☐ Yes ☐ No

If yes, explain ______________________

Date of most recent examination ______________________

Are you aware of any current health problems? ☐ Yes ☐ No If yes, explain ______________________

Is there any disease, accident, illness or past/present history related to the following? (If yes, please give dates and full details.)

	No	Yes	Year		No	Yes	Year		No	Yes	Year
Serious Illness/Injury	☐	☐	____	Appendicitis	☐	☐	____	Rheumatic Fever	☐	☐	____
Surgery	☐	☐	____	Kidney Infection	☐	☐	____	Blood	☐	☐	____
Ears/Eyes	☐	☐	____	Back/Limbs/Joint	☐	☐	____	Stomach	☐	☐	____
Teeth/Tonsils	☐	☐	____								

Immunizations	**Last Yr. Given**	**Immunizations**	**Last Yr. Given**	**Have Had**
Tetanus	____	Measles	____	☐ Measles
Diphtheria	____	Mumps	____	☐ Mumps
Polio	____	Rubella	____	☐ Rubella
Hepatitis (A, B or C)	____	Varicella (Chicken Pox)	____	☐ Chicken Pox
(circle one/any)				☐ Tuberculosis

IV. EMERGENCY MEDICAL RELEASE

In consideration of my participation in 4-H activities, I provide the following release. I understand that a health problem or a medical emergency may develop that necessitates the administration of medical care, hospitalization or surgery. In the event of illness or injury, I hereby authorize the University of Tennessee, Tennessee State University, and its representative(s) or agents(s) to secure any necessary treatment, including the administration of anesthetics and surgery. I further give permission to the University of Tennessee, Tennessee State University, and its representative(s) or agent(s) to provide this medical history form to health care personnel. I authorize my physician, health care provider or any hospital to provide reasonable and necessary medical treatment or supplies. Either the original permission or a photostatic copy thereof is valid as an authorization.

I recognize that the event does not provide sickness or accident insurance coverage for participants. I accept responsibility for payments of those medical costs incurred for injuries or illnesses.

I have read this Release and Assumption of Risk Agreement and signed it on behalf of myself, my heirs, assigns and anyone entitled to act upon my behalf.

* Signed ______________________ Date ______________________

Volunteer or Paid Staff Member's Signature Month/Day/Year

*If for any reason you do not sign this, you must complete and sign Form 600-C.

F600B (Rev) 02/14
Programs in agriculture and natural resources, 4-H youth development, family and consumer sciences, and resource development.
University of Tennessee Institute of Agriculture, U.S. Department of Agriculture and county governments cooperating.
UT Extension provides equal opportunities in programs and employment.