# TEXAS 4-H YOUTH DEVELOPMENT FORM
# HSS - HEALTH AND SAFETY STATEMENT
2025-2026

*Revised: 6/2025*

Check One: ☐ Youth ☐ Adult County: ____________ District: ____________

Event: ____________ Event Dates: ____________

## Section I. Participant Information

First Name: ____________ Gender: ☐ Female ☐ Male

Last Name: ____________ Date of Birth: / / Age: ______

Address: ____________ Name of Physician: ____________

City, State, Zip: ____________ Physician's Number: ____________

Phone Number: ( ) - Date of last physical exam: ____________

## Section II. Emergency Contact Information

Contact Name #1: ____________ Relationship: ____________ Contact Name #1: ____________ Relationship: ____________

Phone Numbers: ( ) - ( ) - Phone Numbers: ( ) - ( ) -

Address: ____________ Address: ____________

## Section III. Health History (Check the appropriate answer; if YES, use space to the right to provide additional information)

| Question | No | Yes | |
|---|---|---|---|
| Have you had any operations or injuries that impede participation? | ☐ No | ☐ Yes | |
| Are there any activities to be limited/discouraged by a physician's advice? | ☐ No | ☐ Yes | |
| Have you had or do you currently have any heart problems? | ☐ No | ☐ Yes | |
| Do you require any accommodation to participate in scheduled activities? | ☐ No | ☐ Yes | |
| Do you have any chronic recurring illness or communicable diseases? | ☐ No | ☐ Yes | |
| Are you allergic to any medications, food or food ingredients, insects, or pollens? | ☐ No | ☐ Yes | |
| Do you require an inhaler, epinephrine injector, or other item that you keep at all times? | ☐ No | ☐ Yes | |
| Do you have a medically prescribed meal plan or dietary restrictions? | ☐ No | ☐ Yes | |
| Do you have Epilepsy? | ☐ No | ☐ Yes | |
| Do you have Diabetes? | ☐ No | ☐ Yes | |
| List any other health related information: | ☐ No | ☐ Yes | |

## Section IV: Medications (ALL medications must be in ORIGINAL container with ORIGINAL LABEL.)

Are there prescribed or over-the-counter medications currently being taken? ☐ No ☐ Yes

If yes, please describe: ____________

## Section V. Insurance Information – Please provide a copy of your insurance card.

Do you carry family medical/hospital insurance? ☐ No ☐ Yes

Carrier: ____________ Policy: ____________

## Section VI. Release of Participant (If minor) at conclusion of activity/camp/event/program

I/We do hereby authorize release of said minor child to the following person/people: (please list all persons, including parents)

____________

Further, I/We require that said minor child NOT be released to the following person/people:

____________

## Section VII. Health and Safety Statement Certification

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand this information is confidential and is to be used only by AgriLife Extension Staff or designated Volunteers for health and safety reasons. I hereby consent to the use of this information for such purposes.

| Participant Certification | Parent/Guardian Certification (only if participant is under the age of 18) |
|---|---|
| Printed Name: ____________ | Printed Name: ____________ |
| Signature: ____________ | Signature: ____________ |
| Date: ____________ | Date: ____________ |

Programs with multiple dates/sessions. I certify this information is correct. Date: ______ Initial: ______ Date: ______ Initial: ______

# 2025-2026 TEXAS 4-H YOUTH DEVELOPMENT PROGRAM

**Program Name**

## WAIVER, INDEMNIFICATION, AND MEDICAL TREATMENT AUTHORIZATION FORM

***1. EXCULPATORY CLAUSE. In consideration for receiving permission to participate in any and all activities of Texas 4-H ("activity"), which is sponsored by Texas A&M AgriLife Extension Service and Texas 4-H Youth Development Program, ("sponsor"), a member of The Texas A&M University System, I hereby release, waive, covenant not to sue, and agree to hold harmless for any and all purposes sponsor, The Texas A&M University System, the Board of Regents for The Texas A&M University System, and their members, officers, agents, volunteers, or employees ("RELEASEES" or "INDEMNITEES") from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while participating in this activity, while traveling to and from the activity, or while on the premises owned, leased, or controlled by RELEASEES, including injuries sustained as a result of the sole, joint, or concurrent negligence, gross negligence, negligence per se, statutory fault, intentional torts, foreseeable criminal acts of third-parties, or strict liability of RELEASEES.***

2. INDEMNITY CLAUSE. I am fully aware that there are inherent risks to myself and others involved with this activity, including but not limited to illness, injury (including death), and damage to personal property, and I choose to voluntarily participate in this activity with full knowledge that the activity may be hazardous to me and my property, and to the person and property of others. I acknowledge there may be physically strenuous activities. I know of no medical reason why I should not participate. ***I agree to indemnify and hold harmless INDEMNITEES*** from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, which may occur to myself, other participants, and third-persons as a result of my participation and conduct in this activity, ***including injuries sustained as a result of the sole, joint, or concurrent negligence, gross negligence, negligence per se, statutory fault, intentional torts, foreseeable criminal acts of third-parties, or strict liability of INDEMNITEES.***

3. WARNING NOTICE. Under Texas Law (Chapter 87, Civil Practice and Remedies Code), a farm animal professional or farm owner or lessee is not liable for an injury to or the death of a participant in farm animal activities, including an employee or independent contractor, resulting from the inherent risks of farm animal activities.

4. NO INSURANCE. I understand that RELEASEES do not maintain any insurance policy covering any circumstance arising from my participation in this activity or any event related to that participation. As such, I am aware that I should review my personal insurance coverage. Sponsor does not carry general liability insurance to cover claims arising from this activity so it seeks a waiver of claims as additional consideration for the right to participate so sponsor, a governmental unit of the State of Texas, can (a) provide the activity at the lowest possible cost to participants; and (b) provide access to a greater number of participants by expending limited resources on program materials rather than on liability insurance.

5. BINDS HEIRS. It is my express intent that this agreement shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representatives, if I am deceased, and shall be governed by the laws of the State of Texas.

6. MEDICAL AUTHORIZATION, INDEMNITY FOR MEDICAL EXPENSES, and WAIVER. I understand RELEASEES cannot be expected to control all of the risks associated with this activity and RELEASEES may need to respond to accidents and potential emergency situations. Therefore, I hereby give my consent for any medical treatment that may be required, as determined by a medical professional at the medical facility, during my participation in this activity with the understanding that the cost of any such treatment will be my responsibility. I agree to indemnify and hold harmless INDEMNITEES for any costs incurred to treat me, even if an INDEMNITEE has signed hospital documentation promising to pay for the treatment due to my inability to sign the documentation. I further agree to release, waive, covenant not to sue, and agree to hold harmless for any and all purposes, RELEASEES from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while receiving medical care or in deciding to seek medical care, including while traveling to and from a medical care facility, ***including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, gross negligence, statutory fault, intentional torts, foreseeable criminal acts of third-parties, or strict liability of RELEASEES.***

7. NO STRICT RULES OF CONSTRUCTION. In the event of a dispute over the meaning or application of this agreement, it shall be construed fairly and reasonably and neither more strongly for nor against either party.

8. VOLUNTARY SIGNATURE. In signing this agreement I acknowledge and represent that I have read it, understand it, and sign it voluntarily as my own free act and deed; sponsor has not made and I have not relied on any oral representations, statements, or inducements apart from the terms contained in this agreement. I execute this document for full, adequate and complete consideration fully intending to be bound by the same, now and in the future. **For students engaging in extracurricular activities:** I understand I can choose not to sign this document and free myself from its terms and the associated risks of the activity by simply not participating in the activity and choosing some other activity available to me that has a lower level of risk to me. I further understand this is a voluntary, extracurricular activity; therefore it is not required for me to obtain college credits and not participating in this activity will in no way hinder my ability to obtain a degree from the university. **For students going on fieldtrips or other class-related activities:** I understand participation in this class/fieldtrip/activity is not mandatory and I will not be penalized for failing to participate in this activity because an alternative activity exists for which I can receive like credit. While I understand alternative activities are available to me that do not have the risks associated with this activity I still desire to voluntarily engage in this activity.

**SIGNING THIS DOCUMENT INVOLVES THE WAIVER OF VALUABLE LEGAL RIGHTS. CONSULT YOUR ATTORNEY BEFORE SIGNING THIS DOCUMENT.**

## EMERGENCY CONTACT INFORMATION

**Emergency Contact Name:** ____________________

**Emergency Contact Number:** ____________________

## PARTICIPANT INFORMATION - ADULT OR YOUTH

**SIGNED** this ____________ day of ____________ , 20 ____________
Date Month Year

**Participant Signature:** ____________________

**Participant Printed Name:** ____________________

**Participant Date of Birth:** ____________________

## PARENT OR GUARDIAN INFORMATION

**If the participant above is under age 18, there should be consent by a parent or guardian, as follows:**

**Parent or Legal Guardian Signature:**
(If Participant is under 18 years old) ____________________

**Parent or Legal Guardian Printed Name:**
(If Participant is under 18 years old) ____________________

INSTRUCTIONS: (1) The document should be printed in a font size no smaller than 10-point type. This is 10-point type. This is 12-point type. (2) The formatting/font style (***bolded, underlined, and italicized***) in paragraph nos. 1, 2, & 5 should not be altered by a system member.

*TAMUS-OGC-Approved 11/17/2025.*

TEXAS A&M AGRILIFE EXTENSION

# Authorization to Dispense Medication

**ADM** 09.01.2020

**Participant:** ______________________ **Food Allergy (if applicable):** ______________________ **Medication (Listed Below)**

**All medication to be administered must comply with the following guidelines:**

1. **All medication, including over-the-counter, must be in the original container.** All prescription medication must be in the participant's name. Sharing of prescription medication is not allowed. Inhalers must be accompanied by the prescription label.
2. All medication must be accompanied by this dated medication authorization form signed by the parent / legal guardian.
3. Please include instructions for over the counter medications.
4. **All medication, including over-the-counter, will be given ONLY as directed on the label.**
5. If there has been a change in the dosage, please send a note from the participant's doctor reflecting the change.

List all medications your child will be taking. **Prescriptions will be given as directed on the label.**

| Medication | Dosage | Time to be given | Special instructions | Staff use only, please do not write here. | | | | | | |
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By signing below, I certify that the information is true and complete. I understand this information is confidential and is to be used only by AgriLife Extension Staff or designated Volunteers for health and safety reasons. I hereby consent to the use of this information for such purposes.

**Parent/Guardian Name** ______________________________________

**Parent/Guardian Signature** ______________________________ **Date** ______________

TEXAS A&M AGRILIFE EXTENSION

**OTC**

# Parent Guardian Authorization, Waiver, & Consent for Over-the-Counter Medication

**Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the youth's parent or guardian. Please complete the following section to save time if your child needs any of these OTC medications during her/his stay. Note: Unless we have parental authorization, we cannot administer ANY medications.**

Participant name ______________________ Date of birth ______________________ Age__________

County ______________________ District__________ Name of Event Attending ______________________

- ☐ Ointments for minor wound care, first aid (Antiseptic, anti -itch, anti-sting, antibiotic, sunburn) as directed.
- ☐ Tylenol/Acetaminophen as directed
- ☐ Ibuprofen as directed
- ☐ Kaopectate or Imodium for diarrhea as directed
- ☐ Rolaids or Tums for acid reflux, heartburn, or indigestion as directed
- ☐ Benadryl for swelling, hives, allergic reaction, as directed
- ☐ Medicated powder for skin irritation as directed
- ☐ Hydrocortisone ointment as directed for mild skinirritations, poison ivy, and insect bites
- ☐ Robitussin or other cough syrup as directed
- ☐ Sunscreen
- ☐ Milk of Magnesia, Pepto Bismol, or Mylanta for upset stomach or nausea as directed.
- ☐ Calamine lotion for bug bites and poison ivy
- ☐ Micatin or anti-fungus treatment as directed for athlete's foot
- ☐ Visine or other eye drops for minor eye irritation
- ☐ Actifed or Sudafed as directed for nasal congestion or allergy relief as directed
- ☐ Throat lozenges and/or spray as directed for sore throat
- ☐ Swimmer's ear drops as directed
- ☐ Medicated lip ointment for dry, chapped lips, lip blisters, or canker sores as directed
- ☐ Bug repellent

Other (list any other approved OTC drugs): ______________________________

Program staff reserve the right to use generic equivalents when available for the name brand over-the-counter medications listed above. I understand that such administration will not be done under the supervision of medical personnel. I also agree that any first aid treatment may be given as needed. I understand that these over-the-counter medications are not necessarily kept on hand and available to be administered immediately.

Any condition which is associated with fever, significant inflammation, and/or does not respond to the above outlined treatment will be followed-up by a consultation with the student's parents. Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I authorize the administration of over-the-counter medications to my child as indicated above. I shall indemnify and hold harmless for any all purposes program staff, The Texas A&M University System, the Board of Regents for the Texas A&M University System, Texas A&M University, Texas A&M AgriLife Extension, the Texas 4-H Youth Development Program and their members, officers, servants, agents, volunteers, or employees (RELEASEES) against any claims that may arise relating to my child being administered the above indicated over-the-counter medications ***including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, intentional torts, or strict liability of RELEASEES.***

I/We have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the program hosted by/at Texas A&M AgriLife Extension.

Participant Name: ______________________ Parent/Guardian Name: ______________________

Parent/Guardian Signature: ______________________ Date: ______________

TEXAS A&M AGRILIFE EXTENSION

**SAP** 05.07.2025

## Parent Guardian Authorization, Waiver, & Consent for Self-Administration of Prescription Medication – Participants 14 years of age or older

This portion of the form must be completed fully in order for participants to self-administer required medication. This form must be completed for each camp/program attended by the youth, for all medications, and each time there is a change in dosage or time of administration of a medication. Program Managers reserve the discretion to use this form.

**Participant Name** ____________________

**Date of Birth** __________ **Age** ______ **County** __________ **District** ______

**Name of Event Attending** ______________ **Event Date(s)** ______________

☐ No, my child does not need to take any prescription medication while at the program.

☐ Yes, my child will need to take prescription medication while at the program.

All prescription medications, including medications for conditions such as food, drug or insect allergies, diabetes; asthma; or epilepsy may be brought to the program under the condition that the participant can self-manage care and delivery of medication with written authorization to do so at program by a parent/legal guardian. Prescription medication must be in its original container labeled by the pharmacist or prescriber. Label must include the name, address and phone number for pharmacist or prescriber. Containers must hold only the amount required for the time the youth will be attending the program.

Medication Name: ______________ Dose: ______________

Specific Directions (i.e. on empty stomach, with water, etc.) ______________

______________________________

Time/Frequency of administration: ______________

Relevant side effects: ______________

Special Storage Requirements (if any): ______________

Is the participant capable of self-managed care? ☐ Yes ☐ No

Prescribing Physician: ______________

Telephone of Physician: ______________

I authorize and recommend self-medication by my child for the above medication. I also affirm that s/he has been instructed in the proper self-administration of the prescribed medication(s) by her/his attending physician. I agree to indemnify and hold harmless for any and all purposes sponsor, The Texas A&M University System, the Board of Regents for the Texas A&M University System, Texas A&M University, Texas A&M AgriLife Extension, the Texas 4-H Youth Development Program and their members, officers, servants, agents, volunteers, or employees against any claims that may arise relating to my child's self-administration of prescribed medication(s) ***including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, intentional torts, or strict liability of RELEASEES.***

Parent/Guardian Name ______________________

Parent/Guardian Signature ______________________ Date __________

*Adapted from Auburn University's Summer Experience Required Form Packet, http://www.auburn.edu/student_info/auband/event/summer_camps/documents/2014_medical_form.pdf*