

**MEDICAL TREATMENT FORM SUPPLEMENT**  
**Contra Costa County 4H Youth Development Program**

Please print or type

\_\_\_\_\_  
4-H Member's first and last name

\_\_\_\_\_  
4-H Camp 2009  
Activity or Event

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
Zip

The following information is needed in order to complete the Health History Information.

Is the above named person allergic to bee stings?

Yes

No

IF yes, please describe symptoms and special treatment instructions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The following information is needed to complete the Medical Treatment Consent.

*I authorize the nurse to give Tylenol as per instructions on the bottle for first aid medication*

Yes

No

*4-H insurance if supplementary to your own medical coverage.* In case of illness or injury, please state your health insurance company, policy and primary insured carrier.

\_\_\_\_\_  
Insurance company name

\_\_\_\_\_  
Policy/group number

\_\_\_\_\_  
Name of primary insured carrier

\_\_\_\_\_  
Signature of parent/legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Emergency daytime phone

\_\_\_\_\_  
Emergency evening phone

\_\_\_\_\_  
Cell/pager number