



LIABILITY RELEASE AND MEDICAL AUTHORIZATION FORM

We give our permission for our son/daughter \_\_\_\_\_ (name) to participate in \_\_\_\_\_ (list activity) on \_\_\_\_\_ (dates including travel) to be held at \_\_\_\_\_ (list location). (List specific nature of activity) \_\_\_\_\_

We hereby release the 4-H leaders, county 4-H program, the New Mexico State University Cooperative Extension Service, the State of New Mexico or their employees, and the owners or operators of any property where the activity may take place, from liability in the event of illness, injury or loss occurring to our son/daughter or their personal belongings and will make no claim as a result thereof.

Should our son/daughter not abide by the established rules of conduct, we understand hat they will be returned home, and we agree to pay for the necessary transportation expenses for them and the accompanying chaperone. Specifically, insubordination, possession and/or consumption of alcoholic beverages, possession and/or use of harmful nonprescribed drugs or substances, destruction of property, cheating or misrepresentation in a competition event, failure to participate in program as scheduled, fighting, disruptive behavior, violation of established curfews and any other policies established by the supervisor designed to assure the safety and well being of the group and individuals will be deemed as just cause for disciplinary action.

We authorize those in charge of the delegation to make medical arrangements for the care of our son/daughter as deemed necessary. We further authorize any licensed medical person/facility to treat our son/daughter. We agree to assume full financial responsibility for any medical services provided.

To the best of our knowledge, our son/daughter is physically able to participate in all aspects of the activity. PLEASE LIST ANY SPECIAL HEALTH FACTORS WHICH YOUR SON/DAUGHTER HAS, SUCH AS ASTHMA, HEART CONDITION, EPILEPSY, DIABETES, ALLERGIC REACTION TO MEDICATION, ETC.:

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

PLEASE LIST ANY PRESCRIBED OR PATENT MEDICATIONS THAT YOUR SON/DAUGHTER WILL BE TAKING WHILE ATTENDING THIS ACTIVITY: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_ Signed: \_\_\_\_\_ Signed: \_\_\_\_\_

Father or Guardian

Mother or Guardian

Parent's/Guardian's Home Phone Number & Address \_\_\_\_\_

Parent's/Guardian's Work Phone Number & Address \_\_\_\_\_

Name & Phone Number of Other Person Who Would Know Whereabouts of Parents \_\_\_\_\_

Name & Address of Family Physician \_\_\_\_\_

Phone Number of Family Physician \_\_\_\_\_

COUNTY \_\_\_\_\_