

MEDIA RELEASE/MEDICAL TREATMENT AUTHORIZATION

Event: _____

Date: _____

County: _____

SECTION I – RELEASE FOR AUDIO, VIDEO, FILM AND PHOTOGRAPHS

All adult and youth participants attending MSU-sponsored events must complete this section of the form. Participants in MSU events are sometimes photographed and videotaped for use in MSU promotional and education materials.

I authorize Michigan State University to record and photograph my image and/or voice or that of my child for use by Michigan State University or its assignees in research, educational and promotional programs. I understand and agree that these audio, video, film and/or print images may be edited, duplicated, distributed, reproduced, broadcast and/or reformatted in any form and manner without payment of fees, in perpetuity.

Subject's name (adult or youth) _____

(please print)

Signature _____ Date _____

(Parent or guardian must sign here if subject is under age 18.)

.....

SECTION II – MEDICAL TREATMENT AUTHORIZATION

This section must be completed and signed by a parent or guardian for all youth participants before they can participate in overnight MSU Extension 4-H activities. If this form is not completed, youth participants will not be allowed to participate. Completing this section is optional but encouraged for adult participants.

Please complete this form to give a medical facility permission to treat the participant for minor injuries or medical problems. In the event of serious injury or illness, the parent or person designated will be contacted. Treatment will proceed before contacting the parent or person designated **only if the situation is urgent and does not permit delay.**

Participant's name _____

Birthdate _____ Phone (_____) _____

Address _____

Social security number _____

Primary care physician's name _____

Physician's address _____

Physician's phone (_____) _____

HEALTH INSURANCE INFORMATION:

Policy holder's name and relationship to participant _____

Policy holder's address _____

Insurance company's name and address _____

If you have HMO insurance, please list emergency treatment authorization phone number

(_____) _____

Employer's name and address _____

Business phone (_____) _____

Subscriber's social security number _____

All policy numbers (please identify) _____

INFORMATION NEEDED ABOUT PARTICIPANT:

Please check yes or no. If yes, explain below or on another sheet if you need more room.

YES NO

Does the participant have any chronic health problem or illness? _____

Does he or she have any acute illness now? _____

Has the person been treated recently for some medical problem? _____

List any medications he or she is now taking for treatment of any medical problem. _____

Does the participant have any allergies to medication or local anesthetics? _____

Does he or she have any allergies? _____

Date of his or her last tetanus shot _____

OFFICIAL AUTHORIZATION FOLLOWS:

I (parent or legal guardian), _____ do hereby authorize the 4-H Youth Development of Michigan State University to seek any medical and/or surgical treatment necessary for the care of my child. The above-designated organization is hereby authorized to incur medical costs necessary to provide treatment for said child, for which I shall be fully responsible. I also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Parent's/Guardian's Signature _____

Date _____

Address _____

Daytime phone (_____) _____

Evening phone (_____) _____