

Cornell Cooperative Extension of Rensselaer County
4-H Volunteer Medical Release Form

Please Print:

Chaperone's Name _____

Address _____

In case of emergency, contact _____ Phone _____

Activity _____ Date(s) _____ Location(s) _____

Activity Director _____

Family Medical and Hospitalization Coverage

Name of Insurance Company or Government Program _____

Identification/Policy # _____

Family Physician's Name and Phone Number _____

I give my permission to be medically treated, as appropriate, in the event of an emergency or illness.

Signature of Chaperone _____

Date _____