

## WASHINGTON 4-H ENROLLMENT FORM

*(Office Use Only)*

County Code:   0          
(0+2-digit-WA county number)

Group Code:           
(3-digit club/group number)

Member Code:                 
(5-digit unique member/leader ID#)

*(Leader fills in this section)*

DATE: \_\_\_\_\_ GEN/ORG. LEADER: \_\_\_\_\_ PHONE: (    ) \_\_\_\_\_

CLUB NAME: \_\_\_\_\_ MAILING ADDRESS: \_\_\_\_\_

**Circle one:**    1-Community Club   2-Sch. Club   3-After-Sch. Club   4-Military Club   5-Spec. Int./Short-Term  
                  6-Overnight Camp   7-Day Camp   8-Sch. Enrichment   9-Individual/Fam. 4-H   10-Sch. Age Care

**PLEASE PRINT**

**Circle one:**    M-Member    G-General/Org. Ldr.    P-Project Ldr.    A-Activity Ldr.    R-Resource Ldr.

**Circle one:**    N-New Enrollment    R-Re-enrollment    D-Drop from Club    Ch-Change/Add Information

**Youth Leader**    **Circle one or more:**    Indirect Volunteer    Direct Volunteer    Middle Manager  
(Members Only)    (Youth Leaders or Adult Leaders Only)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Zip + 4:             -             City: \_\_\_\_\_    State: \_\_\_\_\_

School (Opt.): \_\_\_\_\_    Yr. in 4-H: \_\_\_\_\_    Birthday: \_\_\_\_ / \_\_\_\_ / \_\_\_\_    Gender: M  F

Grade: \_\_\_\_\_ (Yth. only)    Disabled:     Disability: \_\_\_\_\_    Accommodation Needed? Yes  No

Residence: Farm     Rural     Urban     Suburb     Central City     E-mail \_\_\_\_\_  
(Under 10,000)    (Under 50,000)    (Over 50,000)    (Over 50,000)

Ethnic: Hispanic     Not Hispanic

Race: (Check all that apply) White     Black     Alaskan/Am.Indian     Asian     Hawaiian/Pac.Isl.     Other

PROJECT CODE	PROJECT NAME	PROJECT YEAR
Example: FHB	Just Outside the Door	1
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_

Home Ph:          -             Work:          -             Family E-mail \_\_\_\_\_

Leader Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Washington State University Extension

## PHOTO SERVICES RELEASE

I hereby consent and agree that Washington State University, its employees or agents, have the right to take photographs, digital images, or video/ film of me (and/or my property) and to use them for educational and promotional materials. I further consent that my name may be revealed therein or by descriptive text or commentary.

I hereby release to Washington State University, its agents and employees all rights to exhibit this work publicly or privately, including postings to University web pages and to market and sell copies. I waive any rights, claims or interests I may have to control the use of my identity or likeness in the photographs, digital images, video, or film and agree that any uses described herein may be made without compensation.

## MEMBER'S HEALTH FORM

Do you have any physical complaints or illness at this time?  
\_\_\_\_ YES \_\_\_\_ NO  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Are you under the care of a physician or practitioner of any sort?  
\_\_\_\_ YES \_\_\_\_ NO  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Are you taking any type of medication?  
\_\_\_\_ YES \_\_\_\_ NO  
If yes, what type? \_\_\_\_\_  
In what dosage? \_\_\_\_\_

Are you on a special diet?  
\_\_\_\_ YES \_\_\_\_ NO  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you have Diabetes?  
\_\_\_\_ YES \_\_\_\_ NO  
If yes, type and dosage of insulin: \_\_\_\_\_  
\_\_\_\_\_

Do you have Asthma?  
\_\_\_\_ YES \_\_\_\_ NO  
If yes, do you carry an inhaler? \_\_\_\_\_

Do you have allergies?  
\_\_\_\_ YES \_\_\_\_ NO  
If yes, please list allergies: \_\_\_\_\_  
\_\_\_\_\_

Last tetanus shot (month and year)?  
\_\_\_\_\_

Other conditions or comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Physician's Name**                      **Phone Number**

\_\_\_\_\_  
**Health Insurance**                      **Group/Policy Number**

In case of emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the physician selected by the delegation leader to hospitalize and secure proper treatment (including surgery) for my child.

I have read, understand and consent to the foregoing statements.

\_\_\_\_\_  
**Parent/Guardian Signature**                      **Date**

\_\_\_\_\_  
**Participant Signature**                      **Date**