

OHIO 4-H PARTICIPANT/MEMBER HEALTH HISTORY

This form must be completed for each participant by the parents/guardians of minors. This information will be kept confidential and used only for the welfare of the participant.

DATE _____ COUNTY _____

PLEASE CIRCLE: MALE FEMALE AGE _____ DATE OF BIRTH _____

NAME _____
 (LAST) (FIRST) (MIDDLE)

ADDRESS _____
 (STREET) (CITY) (STATE) (ZIP)

PHONE (HOME) _____ GUARDIAN'S WORK PHONE _____

IN CASE OF EMERGENCY, CONTACT:

PARENT NAME _____ PHONE _____

CELL PHONE _____ PAGER _____

OTHER PERSON _____ PHONE _____

PHYSICIAN'S NAME _____ PHONE _____

DENTIST'S NAME _____ PHONE _____

Instructions for Medications

- All prescription drugs **MUST** be carried in the container in which they were issued (with medical orders and physician's name intact), and given to the nurse/health director. Others will not be accepted.
- If you need over-the-counter medications not listed below, they must be in the original container and must be stored under lock and key by the nurse/health director or a responsible adult during the 4-H event.

CHECK MEDICATIONS BELOW, THAT PARTICIPANT MAY RECEIVE IF DEEMED NECESSARY:

<input type="checkbox"/>	Ibuprofen/advil	<input type="checkbox"/>	Acetaminophen/tylenol	<input type="checkbox"/>	laxatives
<input type="checkbox"/>	antacids	<input type="checkbox"/>	triple antibiotic	<input type="checkbox"/>	diarrhea medication
<input type="checkbox"/>		<input type="checkbox"/>	Robitussin Cough Syrup	<input type="checkbox"/>	adrenalin

LIST APPROXIMATE DATE IF PARTICIPANT HAS HAD OR BEEN EXPOSED TO:

CHICKEN POX _____ TUBERCULOSIS _____ MEASLES _____ MUMPS _____

WHOOPING COUGH _____ SCARLET FEVER _____ TETANUS IMMUNIZATION _____

Date of Last Booster _____ Date of Last Menstrual Period _____

Operations or Serious Injuries requiring medical treatment (specify): _____

Check below if participant is subject to:

<input type="checkbox"/>	headaches	<input type="checkbox"/>	fainting	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	frequent colds
<input type="checkbox"/>	constipation	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	frequent sore throats	<input type="checkbox"/>	kidney trouble
<input type="checkbox"/>	athlete's foot	<input type="checkbox"/>	sinusitis	<input type="checkbox"/>	bed wetting	<input type="checkbox"/>	sleep walking
<input type="checkbox"/>	ear infection	<input type="checkbox"/>	epileptic seizures	<input type="checkbox"/>	home sickness	<input type="checkbox"/>	bronchitis
<input type="checkbox"/>	cramps	<input type="checkbox"/>	diarrhea	<input type="checkbox"/>	asthma controlled (yes, no)	<input type="checkbox"/>	other please specify

Check if Participant is Allergic to:

Foods (specify) _____

Medication: Prescription or non-prescription drugs (specify) _____

Serious Ivy, Oak, or Sumac Poisoning _____

Bee or Insect Stings _____ Prescribed Treatment _____

LIST ALL PRESENT MEDICAL AND ALLERGIC CONDITIONS (Contact Lenses, Braces, Diabetes, etc.) which require medication, treatment, or special restrictions or considerations in participation.

Conditions: _____

Medications: _____

SPECIFY ANY RESTRICTIONS IN ACTIVITIES (INCLUDING SPECIAL DIET NEEDS):

Immunization Record

Please record the date (month & year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (whooping cough) DPT* Tetanus or	1 2 3	1 2
Tetanus TD* Diphtheria or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given (most recent)		
Hemophilus influenza b (HIB)		

PARENT/GUARDIAN MEDICAL RELEASE

_____ (Child's name) has my permission to participate in the Camp program and activities (with the exception of those restricted activities listed). I understand participants will be supervised. I understand the camp staff and volunteers, are not responsible in the event of accidental injury or illness, nor for the compounded injury or illness to the participant's present medical conditions listed. I further understand in case of serious injury or illness I will be notified. If I cannot be contacted, I give my permission to transport the participant to an appropriate facility and I give the attending physician my permission to hospitalize, secure proper treatment, and to order injection, anesthesia, or surgery for the participant as named above.

Signature _____ Date _____

I give The Ohio State University permission to publish in print, electronic, or video format the likeness or image of my child. I release all claims against the University with respect to copyright ownership and publication including any claim for compensation related to use of the materials.

Signature _____ Date _____