

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.

Event: _____ Date of Event: _____

Location of Event: _____

[] FEMALE [] MALE AGE _____ DATE OF BIRTH _____

NAME _____
Last First Middle

ADDRESS _____
Street City State Zip

PHONE (Home) _____ PARENT/ GUARDIAN'S WORK PHONE _____

CELL PHONE _____

IN CASE OF EMERGENCY, CONTACT:

PARENT/GUARDIAN'S NAME _____ PHONE _____

OTHER PERSON _____ PHONE _____

PHYSICIAN'S NAME _____ PHONE _____

INSTRUCTIONS FOR MEDICATIONS

1. All prescription drugs MUST be carried in the container in which they were issued (with medical orders and physician's name intact), and give to the nurse/health director. Others will not be accepted.
2. 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:

Nonaspirin pain medication	Acetaminophen/Tylenol	Laxatives
Antacids	Antiseptics	Diarrhea Medication
Coriciden D	Robitussin Cough Syrup	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:

Headaches	Fainting	Heart Trouble	Frequent Colds
Constipation	Convulsions	Frequent Sore Throats	Kidney Trouble
Athlete's Foot	Sinusitis	Bed Wetting	Sleep Walking
Ear Infection	Epileptic Seizures	Home Sickness	Bronchitis
Cramps	Diarrhea	Asthma Controlled (yes _____ or no _____)	

Other: Please specify _____

Check if participant is allergic to:

Foods (Specify) _____

Medications, Prescription or Non-Prescription Drugs (Specify) _____

Serious Ivy, Oak, or Sumac Poisoning _____

Bee or Insect Stings _____ Prescribed Treatment _____

OTHER _____

OVER --->

LIST ALL OTHER CONDITIONS (Contact Lenses, Braces, etc.) and associated restrictions in activities:

Conditions: _____

Medications: _____

Specify any restrictions in activities: _____

IMMUNIZATION RECORD

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

Vaccines	Year of Basic Immunizations	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

_____ has my permission to participate in the Ohio 4-H program and activities (with the exception of those restricted activities listed). I understand participants will be supervised. I understand that the 4-H staff and volunteers, Ohio State University Extension, and The Ohio State University are not responsible in the event of accidental injury or illness, nor for 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 the attending physician to hospitalize, secure proper treatment and to order injection, anesthesia, or surgery for the participant as named above. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. The 4-H event's nurse/health director has my permission to administer the prescription medications and/or over-the-counter medications.

Signature _____

Parent/Guardian

Date