OHIO STATE UNIVERSITY EXTENSION

# 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: ______________________________

( ) *MALE* ( ) *FEMALE* *AGE:* __________ *DATE OF BIRTH:* ______________

*NAME*: ______________________________
(Last) (First) (Middle)

ADDRESS: ______________________ CITY: ______________ STATE: _____ ZIP: _____

HOME PHONE: __________ PARENT/GUARDIAN WORK PHONE: __________ CELL PHONE: __________

**IN CASE OF EMERGENCY, CONTACT:**

PARENT/GUARDIAN 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 given 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 Medicaiton |
| | Coriciden D | | Robitussin Couth Syrup | | Adrenalin |

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

| | | | | |
|---|---|---|---|---|
| Chicken Pox | | Tuerculosis | | 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_____ 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: ______________________________

**LIST ALL OTHER CONDITIONS** (contact lenses, braces, etc) and associated restrictions in activities:

Conditions: ______________________________________________________________________________________________

Medications: _____________________________________________________________________________________________

Specify and restrictions in activities: ______________________________________________________________________

**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<br>Pertussis (whopping cough) DPT<br>Tetanus<br>OR | 1<br>2<br>3 | 1<br>2 |
| Tetanus TD<br>Diphtheria<br>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 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 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 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: ____________________________________________________ Date: ___________________________
Parent/Guardian

THE OHIO STATE UNIVERSITY
COLLEGE OF FOOD, AGRICULTURAL, AND ENVIRONMENTAL SCIENCES

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