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OHIO 4-H PARTICIPANT/MEMBER HEALTH HISTORY

Fairfield County 4-H Camp

This form must be completed for each participants 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 CODE)

PHONE (HOME) ____________________________ GUARDIAN'S WORK PHONE ___________________

INCASE OF EMERGENCY, CONTACT:

PARENT NAME ____________________________ PHONE ____________________________

CELL PHONE ______________________________ PAGER ____________________________

OTHER PERSON ____________________________ PHONE ____________________________

PHYSICIAN'S NAME ________________________ PHONE ____________________________

DENTIST'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 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, no)		other please specify

Check if Participant is Allergic to:

Foods (specify) ____

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

Serious Ivy, Oak, 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:

____

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 (whopping 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 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.

Signature ___________________________________ Date ______________________________________

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Keith L. Smith, Ph.D., Associate Vice President for Agricultural Administration and Director, Ohio State University Extension TDD No. 800-589-8292 (Ohio only) or 614-292-1868
Please call OSU Extension at 740-653-5419 if you wish to participate in programs and require special assistance or modifications for a disability.