

Name _____

County _____

III. HEALTH HISTORY AND MEDICAL RECORD

The information on this form will be provided to any health care providers in case of an emergency. This information will not be used to discriminate against a participant on the basis of any disability.

Name of Physician _____ Phone () _____

Medical/Hospital Insurance _____
Carrier Policy or Group #

CHECK ALL THAT APPLY

Allergy to a medicine, food, plant, or insect toxin. Explain _____

Is participant allergic to the following drugs: Penicillin Sulfa Drugs Tetracycline, Aspirin

List allergies to other drugs or allergens _____

Any condition that may require special care, diet or restriction of activities for medical reasons. Explain _____

Asthma Heart Trouble Nose Bleeds Diabetes Convulsions Fainting Spells

Do you wear? Dentures Contact Lens Other (Explain) _____

Is any medication, including medication for behavior modification, being taken at the present time? Yes No
If yes, explain _____

Date of most recent examination _____

Are you aware of any current health problems? Yes No If yes, explain _____

Is there any disease, accident, illness or past/present history related to the following? (If yes, please give dates and full details.)

	No	Yes	Year		No	Yes	Year		No	Yes	Year
Serious Illness/Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Back, Limbs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach	<input type="checkbox"/>	<input type="checkbox"/>	_____
Teeth, Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____								

Immunizations	Last Yr. Given	Immunizations	Last Yr. Given	<input type="checkbox"/> Have Had
Tetanus	_____	Measles	_____	<input type="checkbox"/> Measles
Diphtheria	_____	Mumps	_____	<input type="checkbox"/> Mumps
Polio	_____	Rubella	_____	<input type="checkbox"/> Rubella
Hepatitis (A, B, or C) (circle one/any)	_____	Varicella (Chicken Pox)	_____	<input type="checkbox"/> Chicken Pox
				<input type="checkbox"/> Tuberculosis

IV. EMERGENCY MEDICAL RELEASE

In consideration of my participation in the 4-H activity or event, I provide the following release. I understand that a health problem or a medical emergency may develop that necessitates the administration of medical care, hospitalization or surgery. In the event of illness or injury, I hereby authorize Oklahoma State University and its representative(s) or agents(s) to secure any necessary treatment, including the administration of anesthetics and surgery.

I further give permission to Oklahoma State University and its representative(s) or agent(s) to provide this medical history form to health care personnel. I authorize my physician, health care provider or any hospital to provide reasonable and necessary medical treatment or supplies. Either the original permission or a photo static copy thereof is valid as an authorization. I recognize that sickness and accident insurance may not provide full coverage for participants in this activity or event. I accept responsibility for payments of those medical costs incurred for injuries or illnesses. I have read this Release and Assumption of Risk Agreement and signed it on behalf of myself, my heirs, assigns and anyone entitled to act upon my behalf.

*Signed _____ Date _____

Volunteer or Paid Staff Member's Signature

Month, Day, Year