

# OKLAHOMA 4-H ADULT HEALTH FORM

Name of Adult \_\_\_\_\_

Home Address \_\_\_\_\_  
(No and Street) (City) (State) (Zip)

Person to Contact/Emergency \_\_\_\_\_ Day Phone No. \_\_\_\_\_

Home Address \_\_\_\_\_ Night Phone No. \_\_\_\_\_

To my knowledge, I have no health problems, unless stated below, and can SAFELY PARTICIPATE in \_\_\_\_\_ and that I have no contagious or communicable disease. My health is POOR FAIR GOOD (strike out words that do not apply) and I have had no illness within 30 days prior to departure. In case of an emergency while participating in this event/program, permission is given for physicians to perform needed treatment. I will assume all financial obligations incurred if not covered by insurance.

If the answer is "yes" to any of the following, enter the details on the lines provided below, indicating diagnosis, date of injury, name of hospital, length of hospitalization, name of doctor, etc.

- |   | ANSWER<br>YES OR NO |
|---|---------------------|
| 1. NERVOUS OR MENTAL: Problems such as epilepsy, emotional stress, convulsion, loss of consciousness, dizziness, paralysis, frequent anxiety, excessive crying. | _____               |
| 2. LUNG DISEASE: asthma, blood spitting, persistent cough, tuberculosis, abnormal chest-rays  | _____               |
| 3. DISEASE OF HEART OR BLOOD VESSEL INCREASED OR ABNORMAL BLOOD PRESURE   | _____               |
| 4. PAIN IN THE CHEST OR SHORTNESS OF BREATH: Heart murmur, rheumatic fever  | _____               |
| 5. STOMACH OR INTESTINAL TROUBLE: Ulcers, gall bladder or liver disorder, jaundice, hernia, colitis   | _____               |
| 6. ARTHRITIS, DIABETES, KIDNEY OR BLADDER DISEASE   | _____               |
| 7. HAY FEVER OR ALLERGIES   | _____               |
| 8. ALLERGY TO MEDICINES including penicillin, tetanus   | _____               |
| 9. IMPAIRED SIGHT OR HEARING, CHRONIC EAR INFECTIONS  | _____               |
| 10. RECENT SURGICAL OPERATIONS, ACCIDENTS OR INJURIES   | _____               |
| 11. BEEN A PATIENT IN A HOSPITAL (other than #10)   | _____               |
| 12. ANY INFECTIOUS DISEASE OR CONTACT WITH INFECTIUOS DISEASE IN THE PREVIOUS 2 WEEKS   | _____               |
| 13. SKIN DISEASE  | _____               |
| 14. ALLERGY TO FOODS  | _____               |
| 15. CURRENTLY TAKING MEDICINES (list names and doses below)   | _____               |
| 16. UNDER ON-GOING CARE OF A PHYSICIAN (name and phone)   | _____               |
| 17. DO YOU WEAR GLASSES   | _____               |
| 18. DO YOU WEAR CONTACT LENSES  | _____               |

DATE OF LAST FLU SHOT \_\_\_\_\_ DATE OF LAST TETANUS BOOSTER \_\_\_\_\_

Birthdate \_\_\_\_\_ Gender \_\_\_\_\_

Enter details for "Yes" answer(s) listed above: \_\_\_\_\_

Medicine Being Taken \_\_\_\_\_

Family Doctor \_\_\_\_\_ Doctor's Phone No. \_\_\_\_\_

Adult's Signature \_\_\_\_\_ Date \_\_\_\_\_