OHIO 4-H PARTICIPANT/MEMBER HEALTH HISTORY

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 _____