OFFICIAL 4-H HEALTH FORM Rev. 9-09

County_____

Type of activity: ☐**county/area** ☐ **state** ☐ **regional** ☐ **national** (check one)

Name of event/activity_____

Participant's Name: _____
Last First M.I.

Address: _____ - _____
Street Address

_____ _____ _____
City State Zip Code

Participant is: ☐ Adult ☐ Youth ☐ Male ☐ Female _____ _____ _____
Grade Birth Date Home phone

Emergency Contact: _____ _____
Name Relationship

_____ _____
Daytime phone Evening phone

_____ _____
Cell phone Other

Health Statement (to be completed by parent, physician or adult participant)

Is the participant currently under medical treatment? (describe)	Yes	No	Does the participant have any history of respiratory illness? (describe)	Yes	No
Is the participant diabetic?	Yes	No	Is the participant subject to seizures of any kind?	Yes	No
Date of last tetanus shot?					
Is there any medical condition (heart condition, etc.) or malformation now existing that may require treatment or affect the participant's participation in this program?				Yes	No
Has the participant had recent surgical operations or accidents or been exposed to infectious disease within the last two weeks? (Please bring notification to the activity if this changes prior to the event)				Yes	No
Does the participant have any allergies or dietary restrictions? If yes, please describe:				Yes	No
Name of all medications:					
Name and phone number of physician:					

Accommodations*: OSU and the 4-H Youth Development Program do not discriminate against otherwise qualified participants with disabilities on the basis of disability, Are there any accommodations that you are requesting for yourself or your child in order to participate in the 4-H Youth Development Program?
Yes _____ No _____ If yes, please describe: _____

*Accommodations may include: speech, hearing or vision impairments that may effect participation, behavior disorders or emotional disturbances or abnormally severe moodiness, sleepwalking, and the ability to carry heavy objects, participate in strenuous travel or physical labor.

As parent or guardian, if my child needs medical attention, I understand every effort will be made to contact me. I hereby give permission to the medical personnel selected by the person in charge of the 4-H event to order x-rays, routine tests, treatment, release any records necessary, and to provide or arrange necessary related transportation for the person named on this form. I hereby give permission to the physician selected by the person in charge of the 4-H event to hospitalize, secure emergency treatment for, to order injection, anesthesia, and/or surgery for me or my child as named on this form. I will assume all financial obligations incurred if not covered by insurance.

_____
Signature of Parent/Guardian or Adult participant Date