

# Ohio 4-H Health Statement

ALL SIDES of this form MUST be completed for each participant. Minors must have the form completed and signed by a parent/guardian. This information will be kept confidential and used only for the welfare of the participant. PRINT neatly using blue or black ink.

**REQUIRED!**  
**Attach Picture**  
 (for I.D. purposes only)

## Participant/Member Information:

Name: _____		
(Last)	(First)	(Middle)
Address: _____		
(Street)	(City)	(State) (Zip)
Home Phone: _____	County: _____	
Date of Birth: _____	Male/ Female	Age (today): _____

## Emergency Contact Information:

Parent/Guardian Name: _____	Cell Phone: _____	Email: _____
Other Contact/Relationship: _____	Cell Phone: _____	Email: _____
Other Contact/Relationship: _____	Cell Phone: _____	Email: _____
Physician: _____	Phone: _____	
Dentist: _____	Phone: _____	

## Health History:

### Communicable Diseases:

Provide the date (approximate is acceptable) at which participant has had or was exposed to:

Chicken Pox \_\_\_\_\_ Measles \_\_\_\_\_ Whooping Cough \_\_\_\_\_  
 Tuberculosis \_\_\_\_\_ Mumps \_\_\_\_\_ Other Communicable Diseases \_\_\_\_\_

### Immunization/Vaccine Record:

To the best of knowledge, the participant is up-to-date on all immunizations which may include, but is not limited to: Diphtheria/Pertussis (Whooping Cough-TDAP), Polio, Measles/Rubella/Mumps (MMR), Haemophilus Influenza (HIB), Varicella (Chickenpox) that are required for school.

The participant has received a Tetanus Booster. Date of last booster: \_\_\_\_\_

*If the participant is not current or up-to-date with immunizations, please complete the Ohio 4-H Immunization Exemption Form.*

### Instructions for Medications:

- 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. Other prescription drugs will not be accepted. Only bring the amount needed for your stay at camp.
- If you need regular over-the-counter medications, they must be in the original container. Like prescription medications, these medications must be given to the nurse/health director.
- All medications will be given as directed on the original package/container. If there are any dosage adjustments, you must bring signed documentation from your physician.

## Medical Instructions: Medications/Allergies, Current/Past Medical Conditions:

Current Medications (Prescribed and Over-The-Counter, Current or Past Medical Treatment):  
 (please list additional medications or needs on a separate sheet)

Name of Medication:	Dosage:	Frequency/Instructions:



**Check below if the participant is subject to any of the following conditions:**

<input type="checkbox"/> Asthma Controlled? yes/no	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Cramps	<input type="checkbox"/> Fainting	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Seizures	<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Athlete's Foot	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Home Sickness	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Other?
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Headaches	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Sleep Walking	

**Allergies:**

If none, please write NONE here: \_\_\_\_\_

Food allergies: \_\_\_\_\_

Medication allergies: \_\_\_\_\_

Serious Ivy, Oak or Sumac Poisoning: What is the prescribed treatment? \_\_\_\_\_

Serious bee or insect sting reactions: What is the prescribed treatment? \_\_\_\_\_

*NOTE: If participant's allergy may require use of an "EPI-PEN", then the participant must provide the "Epi-Pen(s)" and discuss possible administration with health care professional upon arrival to camp.*

**Check below if the participant displays any of the following behaviors:**

<input type="checkbox"/> Abusive to Others	<input type="checkbox"/> Easily Distracted	<input type="checkbox"/> Manipulative	<input type="checkbox"/> Self Abusive	<input type="checkbox"/> Withdrawn/Shy
<input type="checkbox"/> Bites	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Severe Fears (Please comment) _____	<input type="checkbox"/> Behavior Plan in Place (please attach a copy or description)
<input type="checkbox"/> Easily Discouraged	<input type="checkbox"/> Inappropriate Language	<input type="checkbox"/> Runs Away	<input type="checkbox"/> Short Attention Span	<input type="checkbox"/> Other? _____

**Accommodations for Camp:**

Please tell us about the accommodations your child may need at 4-H camp:

- I will be bringing medications to camp (please describe whether they require refrigeration or special storage below).
- I have dietary restrictions (describe below).
- I have limited mobility (e.g. crutches, cane, etc.).
- I have ADHD or a related attention deficit disorder; a visual, hearing, cognitive processing, reading, or a speech impairment. (describe any needs you anticipate at camp and the accommodations you typically receive at school and home below).
- I require the use of medical equipment that needs electricity (describe below).
- I require other accommodations not listed above (describe below).
- I do NOT require any special accommodations (none of the above apply to me).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Description of any past or current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp: \_\_\_\_\_

Description of any camp activities from which my child should be exempted for health reasons: \_\_\_\_\_

**Check medication(s) that participant may receive if deemed necessary and administered by a health professional. Examples of brand names are given in parentheses. Generic or other name brands may be provided:**

<input type="checkbox"/> Acetaminophen ( ex: Tylenol)	<input type="checkbox"/> Antibiotic Ointment (ex: Neosporin)	<input type="checkbox"/> Dramamine	<input type="checkbox"/> Poison Ivy Medicine (ex: Calamine Lotion)
<input type="checkbox"/> Aloe Lotion	<input type="checkbox"/> Cough Syrup/Drops	<input type="checkbox"/> Ibuprofen (ex: Advil, Motrin)	<input type="checkbox"/> Sore Throat Medicine
<input type="checkbox"/> Antacids (ex: Maalox, Tums)	<input type="checkbox"/> Decongestant (ex: Sudafed)	<input type="checkbox"/> Insect Repellent	<input type="checkbox"/> Sun Screen
<input type="checkbox"/> Antihistamine (ex: Benadryl, Claritin)	<input type="checkbox"/> Diarrhea Medication (ex: Imodium)	<input type="checkbox"/> Laxative (ex: Milk of Magnesia)	<input type="checkbox"/> Swimmer's Ear Medicine
<input type="checkbox"/> Antiseptics			

**Emergency Medical and Informed Consent/Camp/Program Release**

I understand that my child, \_\_\_\_\_ will be a participant in the Ohio 4-H program and I grant permission for him/her to participate in this program and associated activities with the exception of any restricted activities that I have listed below. I understand that my child must follow the *Ohio 4-H Code of Conduct*; consequences for *Code of Conduct* violations may result in my child being sent home at the sole discretion of OSU Extension at my expense.

I understand that my child is not required to participate in this program, but grant my permission for him/her to do so, despite the potential risks. I recognize that by participating in this program, as with any physical activity, my child may risk personal injury, paralysis and/or death. I understand program participants will be supervised and acknowledge that the 4-H staff and volunteers, OSUE, The Ohio State University, and the 4-H Camp Site are not responsible for any potential injury or illness resulting from my child’s participation. I hereby attest and verify that I have been advised of the potential risks, that I have full knowledge of the risks involved and that I assume any expense that may be incurred in the event of an accident, illness, or other incapacity, regardless of whether I have authorized such expenses.

I understand that most program activities are conducted outdoors and that wearing proper dress (e.g., rain gear, warm clothing) is an essential part of the camp safety rules and procedures. I am aware of and have discussed with my child the established safety rules and procedures.

In the case of serious illness or injury of my child, I understand that I will be notified. If I cannot be contacted, unless otherwise specified below, I grant permission to the attending medical professional to secure proper treatment, hospitalize, and/or take any other action deemed necessary for the immediate care of my child.

In consideration of the opportunity for my child to participate in this program, I, acting for my child, myself and our respective heirs, executors, administrators and assigns, agree to assume any and all risks associated with this activity and do hereby release, indemnify and hold harmless The Ohio State University, its Board of Trustees, OSUE, the Ohio 4-H program, the 4-H camping facility, and their respective officers, agents, and employees from any and all liability, damage, and/or claim of any nature resulting from or arising out of my child’s participation in this program and its activities.

Restricted activities and/or special notification instructions: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Photo and Video Release**

I give permission to The Ohio State University, OSUE, the Ohio 4-H program, and the 4-H camping facility to record and edit into video and/or photographs the likeness, voice, image and video images of my child, \_\_\_\_\_, and to use all or parts of the video or photographs in print or electronic materials for The Ohio State University, OSUE, the Ohio 4-H program, and 4-H camping facility to promote any and all public awareness for the program(s) in which my child is involved.

\_\_\_\_\_  
 Parent/Guardian Printed Name

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Date