

## 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.

### 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: _____	Parent/Guardian Cell Phone: _____
Other Contact: _____	Other Cell Phone: _____
Other Contact: _____	Other Cell Phone: _____
Physician: _____	Physician Phone: _____
Dentist: _____	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.

### 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.*

**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: \_\_\_\_\_

**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.

**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			

**ACKNOWLEDGEMENT OF RESPONSIBILITY AND RELEASE**

I understand and acknowledge that there are certain hazards and risks associated with my child's participation in 4-H educational activities. I understand and accept such risks, and thus waive all claims, demands and causes of action against the State of Ohio, The Ohio State University, the County and their respective trustees, members, officers, employees, agents and volunteers acting on their behalf. I understand that I am solely responsible for any costs arising out of any injury or property damage sustained through my child's participation in 4-H educational programs.

I have had sufficient time to review and seek explanation of the provisions contained above, have carefully read them, understand them fully, and agree to be bound by them. After careful deliberation, I voluntarily give my consent to my child's participation and agree to the terms contained in this Acknowledgement of Responsibility and Release.

I, (printed name) \_\_\_\_\_, am the parent or legal guardian of the 4-H participant. I have read and I understand the provisions of this document, I consent to the participant taking part in the activities described above, and I fully enter into and agree to the above Acknowledgement of Responsibility and Release.

**PERMISSION TO USE CHILD'S PHOTOGRAPHIC FORM FOR PROMOTION**

Ohio State University Extension would like to share the positive results of youth participation in Extension and 4-H Youth Development events. However, in some cases, parents or guardians may prefer not to permit such publicity.

(Please select one)  I GIVE  I DO NOT GIVE the Ohio State University permission to publish in print, electronic, or video formats the likeness or image of my child. I release all claims against the University with respect to copyright ownership and publication including any claim for compensation related to use of the materials. If this section is not completed, publicity about this child's participation will not be used by Ohio State University Extension.

**OHIO 4-H CODE OF CONDUCT**

4-H members, parents, and other adults participating in 4-H activities will:

1. Adhere to program rules, curfews, dress codes, policies, and rules of the facility being used.
2. Conduct themselves in a courteous, respectful manner, use appropriate language, exhibit good sportsmanship, and provide positive role models.
3. Abstain from illegal behaviors, use of alcohol, illegal or illicit drugs, and tobacco during 4-H events and activities.
4. Fully participate in scheduled activities.
5. Respect other's property and privacy rights.
6. Abstain from child abuse (physical and/or verbal) and harassment.
7. Accept personal responsibility for behavior including any financial damage.
8. Be responsible for any financial damage caused by inappropriate behavior.
9. Adhere to rules of safety.
10. I will uphold and support the responsible and lawful use of social media. In so doing, I will not create or post social media content that is abusive, threatening, defamatory, obscene, harassing, or creates a hostile environment.

Consequences for violating any part of this code of conduct may include, but are not limited to: removal from participation in the event in which the code of conduct has been violated (at the individual's expense); sanctions on participating in future 4-H events; forfeiture of financial support for the event; removal from offices held, etc.

Behavior outside of 4-H activities can affect "member in good standing" or "volunteer in good standing" status.

It is the responsibility of all program participants to reinforce the code of conduct and intervene when necessary to enforce the rules.

I have read, understood and thus agree to the above ACKNOWLEDGEMENT OF RESPONSIBILITY AND RELEASE, PERMISSION TO USE CHILD'S PHOTOGRAPHIC FORM FOR PROMOTION, and 4-H CODE OF CONDUCT mentioned above on this \_\_\_\_\_ DAY OF, \_\_\_\_\_ 20\_\_\_\_\_.

I hereby give permission for (printed name of 4-H participant) \_\_\_\_\_ to participate in organized events and activities offered by Ohio 4-H Youth Development Program for the current 4-H enrollment year. It is my understanding that my child will learn, understand and follow established guidelines for safety in the activities in which he/she participates.

\_\_\_\_\_  
Printed Name (4-H Participant)

\_\_\_\_\_  
Signature (4-H Participant)

\_\_\_\_\_  
Printed Name (Parent/Legal Guardian)

\_\_\_\_\_  
Signature (Parent/Legal Guardian)

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## CAREGIVER HEALTH FORM

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Do you give permission to treat in the case of an emergency? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Emergency contact:

Name \_\_\_\_\_ phone \_\_\_\_\_

Physician's name \_\_\_\_\_ phone \_\_\_\_\_

### Health Form

Name \_\_\_\_\_

Check below if participant is subject to:

\_\_\_ headaches      \_\_\_ fainting      \_\_\_ heart trouble      \_\_\_ frequent colds

\_\_\_ constipation      \_\_\_ convulsions      \_\_\_ frequent sore throat      \_\_\_ diabetes

\_\_\_ athlete's foot      \_\_\_ sinusitis      \_\_\_ bronchitis      \_\_\_ sleep walking

\_\_\_ ear infection      \_\_\_ epileptic seizures      \_\_\_ home sickness

\_\_\_ bleeding      \_\_\_ hypertension      (last menstrual period \_\_\_\_\_)

\_\_\_ other \_\_\_\_\_

List any food the participant is allergic to. \_\_\_\_\_

Special dietary needs. \_\_\_\_\_

Medications. prescription or non-prescription drugs

\_\_\_\_\_

Allergies. \_\_\_\_\_

**USE BACK OF THIS FORM AS NECESSARY**