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.

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 PRESSURE ________

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 INFECTIOUS 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: ______________________________________

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Medicine Being Taken ____________________________________________________________

Family Doctor ________________________ Doctor’s Phone No. ______________________

Adult’s Signature _________________________________ ___ Date _______________