

LIST ALL PRESENT MEDICAL AND ALLERGIC CONDITIONS (Contact Lenses, Braces, Diabetes, etc.) which require medication, treatment, or special restrictions or considerations in participation.

Conditions: _____

Medications: _____

SPECIFY ANY RESTRICTIONS IN ACTIVITIES:

Immunization Record

Please record the date (month & year of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria	1	1
Pertussis (whooping cough) DPT*	2	2
Tetanus or	3	
Tetanus TD*		
Diphtheria or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given (most recent)		
Hemophilus influenza b (HIB)		

PARENT/GUARDIAN MEDICAL RELEASE

_____ has my permission to participate in the Ohio 4-H program and activities (with the exception of those restricted activities listed). I understand participants will be supervised. I understand the 4-H staff and volunteers, Ohio State University Extension and The Ohio State University are not responsible in the event of accidental injury or illness, nor for the compounded injury or illness to the participant's present medical conditions listed. I further understand in case of serious injury or illness I will be notified. If I cannot be contacted, I give my permission to the attending physician to hospitalize, secure proper treatment, and to order injection, anesthesia, or surgery for the participant as named above.

Signature _____

Date _____

All education programs and activities conducted by Ohio State University Extension are available to all potential clientele on a nondiscriminatory basis without regard to race, color, creed, religion, sexual orientation, national origin, sex, age, handicap or Vietnam-era veteran status.

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