Adult Medical
Form 4

Today's Date:	County
Program/Camp/Trip/Event:	Overnight Event ☐ YES ☐ NO

PARTICIPANT INFORMATION - REQUIRED

Name of Participant:			
Address:	City:	State:	Zip:
Date Of Birth:	Gender: ☐ M ☐ F		

INSURANCE INFORMATON - REQUIRED

Do you have health/accident insurance? (circle one): ☐ YES ☐ NO

Insurance Company Name:

EMERGENCY CONTACT INFORMATION - REQUIRED

#1 Name	Relationship	Phone:
#2 Name	Relationship	Phone:

HEALTH HISTORY AND MEDICAL RECORD (This section is optional)

Types of Medications being taken ☐ Prescription ☐ Over the Counter	List Medications:

History of Allergies or reactions to:	**Check ALL Allergies/Reactions** ☐ Medication ☐ Insects/stings/bites ☐ Plants ☐ Other	Explain Allergies/Reactions:
History of Food Allergies?	**Check ALL Allergies** ☐ Eggs ☐ Nuts ☐ Dairy ☐ Wheat ☐ Fish/Shellfish ☐ Other	Explain Food Allergies:
Dietary Restrictions or special needs?	Explain Dietary Needs:	
Physical, behavioral or mental health condition that would limit participation in normal activities/projects?	**Check ALL that apply** ☐ ADD/HDHD ☐ Epilepsy/Convulsions ☐ Asthma ☐ Heart/Lung ☐ Autism/Asperser's ☐ Nose Bleeds ☐ Diabetes ☐ Other	Explain Condition/Limitation(s):
Do any of the following Medical Assistance apply?	**Check ALL that apply** ☐ Dentures/Dental Plate/Partial/Retainer ☐ Prosthetic ☐ Glasses/Contact Lenses ☐ Wheelchair/Walker/Cane/Crutches ☐ Hearing Aid/Implant ☐ Other	Other: (Explain)

Revised 7/2018

EMERGENCY MEDICAL RELEASE

I understand that a health problem or a medical emergency may develop that necessitates the administration of medical care, hospitalization or surgery. I further recognize and understand that there may be situations where I require immediate medical or hospital care, and it may not be possible to give my consent. In such situations, I give permission to Oklahoma State University and its representative(s) or agent(s) to provide this medical history form to health care personnel. I further authorize a physician, surgeon, other health care provider, or dentist to exercise his/her professional judgment and assess the risks and choose the necessary treatment from any available alternatives and to render such care and perform such treatment as he/she in his/her professional judgment determines to be necessary for my health and safety, and I authorize any hospital, clinic, or other health care provider to provide reasonable and necessary medical treatment or supplies.

For personal reasons I decline medical treatment Signature _____ Date _____

By signing below, I authorize the medical information on this form to be provided to any health care providers in case of an emergency.

Signed: _____ Date: _____

Volunteer/Paid Staff/OCES Employee MM/DD/YY