


**Adult Medical
Form 4**

Today's Date:		County	
Program/Camp/Trip/Event:			Overnight Event <input type="checkbox"/> YES <input type="checkbox"/> NO
PARTICIPANT INFORMATION - REQUIRED			
Name of Participant:			Date Form Completed
Address:	City:	State:	Zip:
Date Of Birth:		Gender at Birth: <input type="checkbox"/> M <input type="checkbox"/> F	
EMERGENCY CONTACT INFORMATION			
#1 Name	Relationship	Phone:	
#2 Name	Relationship	Phone:	
INSURANCE INFORMATION			
Do you have health/accident insurance? (circle one): <input type="checkbox"/> YES <input type="checkbox"/> NO			
Insurance Company Name:			
Medications	Types of Medications being taken		List Medications:
	<input type="checkbox"/> Prescription (Must complete pg. 6) <input type="checkbox"/> Over the Counter <input type="checkbox"/> None at this time		
MEDICAL MARIJUANA - OSU receives federal funds and must comply with the Federal Drug-Free Schools and Communities Act and the Federal Drug-Free Workplace Act. While the use of medical marijuana has been legalized in the state of Oklahoma, federal law prohibits the use, possession or cultivation of marijuana for any reason on the OSU campus and also prohibits the use and distribution of marijuana for any reason at events authorized or supervised by OSU (which includes programs offered by the Oklahoma Cooperative Extension Service and 4-H).			
History of Allergies or reactions to:	Check ALL Allergies/Reactions <input type="checkbox"/> Medication <input type="checkbox"/> Insects/stings/bites <input type="checkbox"/> Plants <input type="checkbox"/> Other <input type="checkbox"/> No Known Allergies		Explain Allergies/Reactions:
History of Food Allergies?	Check ALL Allergies <input type="checkbox"/> Eggs <input type="checkbox"/> Nuts <input type="checkbox"/> Dairy <input type="checkbox"/> Wheat <input type="checkbox"/> Fish/Shellfish <input type="checkbox"/> Other <input type="checkbox"/> No Known Food Allergies		Explain Food Allergies:
Dietary Restrictions or special needs?	Explain Dietary Needs:		
Physical, behavioral or mental condition that would limit participation in normal activities/projects?	Check ALL that apply <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Epilepsy/Convulsions <input type="checkbox"/> Asthma <input type="checkbox"/> Heart/Lung <input type="checkbox"/> Autism/Asperger <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Diabetes <input type="checkbox"/> Other		Explain Condition/Limitation(s):

Do any of the following Medical Assistance apply?	Check ALL that apply		Other: (Explain)
	<input type="checkbox"/> Dentures/Dental Plate/Partial/Retainer <input type="checkbox"/> Glasses/Contact Lenses <input type="checkbox"/> Hearing Aid/Implant	<input type="checkbox"/> Prosthetic <input type="checkbox"/> Wheelchair/Walker/Cane/Crutches <input type="checkbox"/> Other	

Medical Release

Oklahoma State University/Langston University and the 4-H Program need accurate information to provide and/or seek appropriate Medical treatment for adults participating in some Programs. In cases where medical attention is necessary, the Emergency Contact will be contacted when possible; however, in the event of an emergency the 4-H staff/volunteer will seek medical care for any Participant until which time a legal representative can assume responsibility for the individual’s care and treatment.

I understand the position of OSU and 4-H Youth Development in my care and treatment. _____ Adult’s Initials

Medical History – I understand it is my responsibility to provide complete and accurate information regarding mental, physical, or medical condition to participate in this Program. If uncertain about any pre-existing medical condition(s), it is my responsibility to consult with my physician prior to participating in this Program. As a participant, it is my responsibility to disclose relevant information that may result in harm to Participant and/or others during this Program. Furthermore, it is my responsibility to notify the 4-H program and/or Oklahoma State University/Langston University of any changes in the mental, physical, or medical condition of the Participant which may impact their participation in the Program.

Medical information disclosed will not be used by University personnel, employees, the 4-H program, or volunteers to determine a Participant’s ability to participate safely in the Program. This information will be kept in strict confidence and will only be shared with my permission or as necessary in the event of an emergency.

I understand that, if Participant chooses to participate in activities, it is done voluntarily and of my own accord.

It is my responsibility to provide a current or updated health form (online or paper) as needed to participate in Programs.

Assumption of Risk and Release

Being fully familiar with the activities of the 4-H Program, I further acknowledge that the performance of the volunteer work and participation in the activities involved in said work and/or events are not without some inherent dangers, hazards and risks of injury, including bodily injury and death. As such, I do hereby agree to assume all of the risks and responsibilities surrounding my volunteer activities and I do for myself, my heirs, and personal representatives hereby agree to release, waive, forever discharge and covenant not to sue the Oklahoma 4-H Program, the OSU/Langston Extension Service, Oklahoma State University/Langston University, the governing Board of Regents of the universities, and all officers, agents, and/or employees thereof from and against any and all claims, demands, and actions or causes of action on account of damage to personal property or personal injury or death which may result from the performance of my volunteer duties, my activities and/or my participation in the activities or events thereof. I further understand I will be responsible for the costs associated with my care and treatment related to any such accident, injury or loss.

By signing below,

1. I authorize the medical information on this form to be provided to any health care providers in case of an emergency
2. I have been fully informed position of OSU and 4-H Youth Development in my care and treatment
3. I have been informed of the Universities Assumption of Risk and Release

Signed: _____

Date: _____

Volunteer/Paid Staff/OCES Employee

MM/DD/YY