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:

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** ☐ 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)

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

Revised 6/2019