

Name: _____
(Print Last Name) (Print First Name)

**ADULT MEDICAL HISTORY AND CONSENT
FOR EMERGENCY TREATMENT**
University of Wisconsin 4-H & Youth Development Programs
Winter Adventures Workshop
February 15-17, 2008

This information is confidential and necessary for proper care by staff advisors and medical personnel.
Information must be legibly printed in black ink or typed. Do not leave empty blanks; enter N/A if not applicable.

Participant Information:

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Height _____ Weight _____ o Female o Male

Health Information: Have you experienced any of the following illnesses/injuries/diseases/disorders/problems or symptoms? If you check "yes" to any of the following, **enter the details below** including diagnosis, treatment, date of illness or injury, name of hospital, name of physician and telephone number. Continue on reverse side of page, if necessary.

YES	NO	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to bee stings. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to dyes (red dye, food coloring). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to environmental factors (pollen, mold, dust, hay fever). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to foods. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to latex. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medicines including penicillin, tetanus, etc. Explain _____ How do you react to the(se) allergy(ies)? _____ Normal treatment? _____
<input type="checkbox"/>	<input type="checkbox"/>	Bladder or bowel control problems. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or hypoglycemia (low blood sugar). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorders (anorexia, bulimia or other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Emotional or mental (reaction to stress, frequent anxiety, excessive fears, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to a contagious or serious disease recently. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Eye or ear (color blindness, peripheral vision, depth perception, near or farsightedness, ear infection, impaired hearing or other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart (high/low blood pressure, murmurs, chest pain, rheumatic fever, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or gall bladder. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Limiting physical conditions (sitting, standing, walking). Is special equipment or assistance needed? Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal (arthritis, recent fractures, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Nervous system (breakdown, convulsions, dizziness, epilepsy, loss of consciousness, paralysis, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Nose or throat (thyroid, lymph nodes, carotid arteries, other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Reproductive (menstrual difficulties, other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory (asthma, persistent/chronic cough, abnormal chest x-ray, tuberculosis, or any other lung problems). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Skin (rash, other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Sleep (sleep apnea, sleepwalking, recurrent nightmares, other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach, liver or intestinal (ulcers, jaundice, hernia, colitis, indigestion, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Surgical operations, accidents or injuries in the past 2 years. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Vascular and blood (anemia; Hepatitis B or C; hemophilia, HIV positive; HBV; migraines, nosebleeds, transfusions, unconsciousness/fainting, other). Explain _____

(over)

Continued explanations of "yes" answers:

Dietary needs/restrictions:

List special dietary needs or restrictions: _____

General attitude/mood/alertness (shyness, energy level, cooperation) _____

Immunizations: list dates of last vaccines. Hepatitis _____ Influenza _____ Tetanus _____

Medications:

List all prescriptions/non-prescription medications participant will require during the program, listing dosages, time medications are taken, and sensitivity to them: _____

Social habits (smoking or chewing tobacco, alcohol consumption, illicit drug use). Explain _____

Insurance information:

Insurance Co. _____ Policy Number _____
Address _____ City _____ State _____ Zip _____
Telephone number: _____

Physician information:

Family physician or clinic _____ Phone (_____) _____
Date of last medical examination: _____ Are you under a doctor's care now? yes no

Emergency Contact:

Last name _____ First name _____ MI _____
Address _____ City _____ State _____ Zip _____
Day phone _(_____) _____ Evening phone _(_____) _____
Relationship _____

Alternate contact in case of emergency:

Name _____ Relationship _____
Day phone _(_____) _____ Evening phone _(_____) _____

I understand that failure to provide complete information on this health form could hinder staff's ability to provide adequate care and could result in termination of my participation in this event.

*I consider my health to be: Excellent Good Fair Poor. I believe that I can **safely participate** in this program. I further declare that I have no physical, mental, or communicable conditions that will interfere with participation in this program.*

I understand that if a serious illness or injury develops, medical and/or hospital care will be given but Wisconsin 4-H and program staff are not responsible in case of accidental injury or illness. The person noted above will be notified as soon as possible in case of medical emergency while I am participating in this program. If a medical emergency arises, I give permission for emergency treatment or surgery as recommended by an attending physician. I agree to cover the cost of prescriptions and emergency transportation to medical facilities or home, if necessary.

Signature _____ Date _____

SEND THIS COMPLETED FORM WITH REGISTRATION