

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

**YOUTH HEALTH INFORMATION &
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.
Print legibly in black ink or type. 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: Has this delegate 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, telephone number; may continue on reverse side of page.

YES NO CONDITION

- Allergies to bee stings. Explain _____
- Allergies to dyes (red dye, food coloring). Explain _____
- Allergies to environmental factors (pollen, mold, dust, hay fever). Explain _____
- Allergies to foods. Explain _____
- Allergies to latex. Explain _____
- Allergies to medicines including penicillin, tetanus, etc. Explain _____
How does this person react to the(se) allergy(ies)? _____
Normal treatment? _____
- Bladder or bowel control, bedwetting. Explain _____
- Diabetes or hypoglycemia (low blood sugar). Explain _____
- Eating disorders (anorexia, bulimia or other). Explain _____
- Emotional or mental (severe homesickness, reaction to stress, frequent anxiety, excessive fears, etc.).
Explain concern and suggested method of handling it _____
- Exposure to a contagious or serious disease recently. Explain _____
- Eye or ear (color blindness, peripheral vision, depth perception, near or farsightedness, ear infection, impaired hearing or other). Explain _____
- Heart (high/low blood pressure, murmurs, chest pain, rheumatic fever, etc.).
Explain _____
- Kidney or gall bladder. Explain _____
- Learning or attention disorders. Explain _____
- Limiting physical conditions (sitting, standing, walking). Is special equipment or assistance needed?
Explain _____
- Muscular/skeletal (arthritis, recent fractures, etc.). Explain _____
- Nervous system (convulsions, epilepsy, dizziness, etc.). Explain _____
- Nose or throat (thyroid, lymph nodes, carotid arteries, other). Explain _____
- Reproductive (menstrual difficulties, other). Explain _____
- Respiratory (asthma, persistent/chronic cough, abnormal chest x-ray, tuberculosis, or any other lung problems). Explain _____
- Skin (rash, other). Explain _____
- Sleep (sleepwalking, recurrent nightmares, other). Explain _____
- Stomach, liver or intestinal (ulcers, jaundice, hernia, colitis, indigestion, etc.). Explain _____
- Surgical operations, accidents or injuries in the past 2 years. Explain _____
- 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:

Other important health information that the adult advisors should know? _____

Contagious diseases: List date of exposure and occurrence of the following: Measles, Mumps, Rubella, Chicken Pox, Mononucleosis, Tuberculosis, Pneumonia _____

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 _____ MMR (Measles/Mumps/Rubella) _____

Was this a second MMR immunization? yes no

Medications:

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

Do you want an adult advisor to collect and dispense medications? yes no

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: _____ Is participant under a doctor's care now? yes no

Parent/Guardian information:

Last name _____ First name _____ MI _____

Address _____ City _____ State _____ Zip _____

Day phone _(_____)_____ Evening phone _(_____)_____

Alternate contact in case of emergency:

Name _____ Relationship to participant _____

Day phone _(_____)_____ Evening phone _(_____)_____

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

I consider _____'s health to be: Excellent Good Fair Poor. I am of the opinion that he/she can safely participate in this program. I further declare that he/she has no physical, mental, or communicable conditions that will interfere with participation in this program.

I understand my son/daughter will be supervised and 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. I or the person noted above will be notified as soon as possible in case of medical emergency while my son/daughter is 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 of Parent/Guardian _____ Date _____

SEND THIS COMPLETED FORM WITH REGISTRATION