

Upham Woods Outdoor Learning Center Health Form

Group Name: _____

Dates of group visit to Upham Woods: _____ through _____

PART ONE: CONSENT FOR MEDICATION ADMINISTRATION and MEDICAL TREATMENT

To the Parent(s) or Legal Guardian:

It is UW-Extension policy to secure your consent for medication distribution and for the use of medical devices if your son, daughter, or ward will be under the age of 18 while at the Upham Woods Outdoor Learning Center. The medication or medical device can be self-administered or be administered by the visiting group's Health Supervisor.

All medications must be in a medicine bottle and labeled with the camper's name, doctor's name and phone number, medication name, and dosage. You must also complete the form below:

_____ No medication has been brought to camp.

_____ I want the medication or medical device administered by the Camp Health Supervisor. However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

Name of Medication (s)	Prescribing Doctor	Doctor's Phone #
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Amount to be taken	How is it taken?	When to be administered
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Day(s) to be taken	Special Instructions
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- If your son, daughter, or ward will be under the age of 18 years while at our camp, it is our policy to secure your consent for medical treatment.
- By signing below you are giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- By signing below you are stating that you are aware of and accept the risk inherent in the program activity.
- By signing below you agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, UW-Extension, their officers, employees and agents, from any and all liability, loss, damages, or expenses which are sustained, or required arising out of the actions of your dependent in the course of the Upham Woods visit.

Participant Name (Please Print)

Signature of Parent or Guardian

Date

PART TWO: HEALTH HISTORY QUESTIONNAIRE

Full Participant Name:		Organization Name:	
Full Home Address:		Home Telephone Number:	Date of Birth: ____/____/____ Sex: M F
Parent/Guardian Name:	Relationship:	Height:	Weight:
Address (if different than above)	Home Telephone Number:(if different than above)	<input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No Other Antibiotics _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Other Medicine (type) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Insect Bites/Stings _____	Does participant have allergic reactions to: <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No Other Antibiotics _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Other Medicine (type) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Insect Bites/Stings _____
Parent/Guardian Work Telephone:		Does participant take medication on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Identify _____ (consent for medication administration must be signed on reverse.)	
Alternate contact in the event that the Parent/Guardian cannot be contacted during an injury or illness. (Name, Relationship, Address, and Telephone Number)		Has participant had or presently experiencing: <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures/Blackouts <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Injury/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Menstrual Difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No Mental/Emotional Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Neck/Back Pain/Injury <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer	
Physician: _____ Telephone: _____ Insurance Co.: _____ Policy No.: _____ Emergency rooms and urgent care facilities in our area strongly advise camp participants to have a copy of their insurance cards with them in the case that they need medical care. Please make a copy of your insurance card and attach it to this medical form.		Other: _____ _____	
Immunization Record		Does the participant have any physical condition(s) requiring special considerations? Explain.	
* MMR (measles, mumps, rubella) Dose 1-Immunization at age 1 <input type="checkbox"/> Yes <input type="checkbox"/> No		A physical examination within 24 months of the camp/event is recommended. Date of participant's last physical examination:	
Dose 2 <input type="checkbox"/> Yes <input type="checkbox"/> No		Has participant ever had major surgery or been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	
* Tetanus-Diphtheria <input type="checkbox"/> Yes <input type="checkbox"/> No		Please explain any significant operations, accidents or illnesses, and last medical attention and reason:	
* Year of last tetanus boost (must be within last 10 years)		Does the participant have any physical condition(s) requiring special considerations? Explain.	