

University of Wisconsin Youth Event Health Form

Event

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| Event Name | Event Date(s) |
|------------|---------------|

Contact Information

| | | | |
|--|--|--------------------|-------------------------|
| Youth Name (last name, first name) | Youth Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male | Birth Date (m/d/y) | Age on 1st Day of Event |
| Parent/Guardian Name (last name, first name) | Address (street, city, state, zip code) | | Email |
| Home Phone | Work Phone | Cell Phone | |
| Second Parent/Guardian Name | Second Address | | Second Email |
| Second Home Phone | Second Work Phone | | Second Cell Phone |

Health Conditions

| | | | |
|--|--|--|---|
| <input type="checkbox"/> Heart: include if physician denied or restricted sports participation | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Dizziness or Fainting | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cognitive or Developmental Please describe: | <input type="checkbox"/> Psychiatric Please describe: | <input type="checkbox"/> Muscular/Skeletal Please describe: | <input type="checkbox"/> Other Please describe: |
| | | | <input type="checkbox"/> Asthma: Is an inhaler required and carried by the youth? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Allergies

| | | | |
|--|--|---|--|
| <input type="checkbox"/> Insect (bee) stings | <input type="checkbox"/> Foods | Please list the allergen and describe the reaction: | Is an EpiPen® required and carried by the youth? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Other, please describe: | | |

Insurance and Tetanus Booster Information

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|---------------------------------------|
| 1. Name of Insurance Company |
| 2. Policy Number |
| 3. Date Of Last Tetanus Booster Shot: |

Accommodations and Special Instructions

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|---|
| 1. Does the youth require an accommodation to participate in this event? Please describe: |
| 2. Please describe any limitations or restrictions regarding the youth's participation in event activities. |
| 3. Is there any other information you want to share? |

Medications

| | | | | |
|---|---|--|--|---|
| Parent/Guardian: Some programs may choose to have limited over-the-counter medications available. Please select which medications can be provided, if they are available. | Acetaminophen (Tylenol) <input type="checkbox"/> Yes <input type="checkbox"/> No | Hydrocortisone (anti-itch) cream <input type="checkbox"/> Yes <input type="checkbox"/> No | Benadryl <input type="checkbox"/> Yes <input type="checkbox"/> No | Ibuprofen <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|--|--|---|

Medications Youth is Bringing to Event

| Prescription Medication Name | Purpose | Dosage (mg) | Times of day given | Side Effects | Prescribing Physician | Physician Phone Number |
|------------------------------|---------|-------------|--------------------|--------------|-----------------------|------------------------|
| | | | | | | |
| | | | | | | |

Please describe any special instructions or additional information regarding medication:

Consent for Medication Treatment and Medication Administration

TO THE PARENT(S) OR LEGAL GUARDIAN(S):

If your son, daughter, or ward will be under the age of 18 while at the University of Wisconsin, it is event/camp policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device can be self-administered or be administered by designated camp health staff with the exception of controlled drugs, **All medication must remain in the original packaging** (bottle labeled with the youth participant's name, doctor's name, medication name, dosage, prescription number, date prescribed, and instructions). A limited amount of medication for life-threatening conditions may be carried by the youth (i.e. EpiPen®, inhaler, etc.). **Please select one option below:**

- No medication(s) has been brought to event/camp.
- The youth participant if age 14 or older, may administer the medication or operate the medical device. Please note that controlled drugs (i.e. Codeine, Ritalin, Adderall, Dexedrine, etc.) must, by law, be administered by health staff.
- The designated health care staff will administer the medication or operate the medical device.



If your son, daughter, or ward will be under the age of 18 years while at the event/camp, it is our policy to secure your consent for all of the following. By signing below as parent/guardian,

- I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- I confirm that I have read the program description and that the youth can participate in planned activities.
- I am aware of and accept the risk inherent in the program activity.
- I attest that all information on both sides of this form is correct.
- I agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin, their officers, agents, and employees from any and all liability, loss, damages, costs, or expenses which are sustained, incurred or required arising out of the actions of my son, daughter or ward in the course of the event/camp.

| | | |
|------------|---------------------------------|------|
| Youth Name | Signature of Parent or Guardian | Date |
|------------|---------------------------------|------|

To be Completed by Event Staff at Check-In

Are there any changes in the youth's health status, medications or other related information since this form was completed?

Yes No

Will the parent, guardian or Emergency Contact be available at this number during the event? Yes No