University of Wisconsin – Extension 2019-20 Youth Event Health Form

Event Name: 2019 YPCL

Dates: Nov. 8-10, 2019

Youth Name: _____ Birth date ___/___/____ Age on 1st day of event AA Sex: ☐Male ☐Female

Custodial Parent/Guardian (or spouse) _____ E-mail address: _____

Phone Numbers: Home (____) ____-____ Work (____) ____-____ Cell phone (____) ____-____

Home address: _____
Street City State Zip

Second parent/guardian
and/or emergency contact: _____ Phone: Home (____) ____-____

Work (____) ____-____

Address: _____
Street City State Zip

Yes	No	Health Conditions (check)
☐	☐	Asthma
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Psychiatric
☐	☐	Cognitive/Developmental
☐	☐	Any dizziness, light-headedness or fainting associated with exercise within the past year?
☐	☐	Any unexplained, rapid or irregular heart beat within the past year?
☐	☐	A physician has sometime denied or restricted participation in sports due to a heart problem.

Yes	No	Allergies (check)	List specifics
☐	☐	Insect stings	
☐	☐	Foods	
☐	☐	Medications	
☐	☐	Other	
☐	☐	Do any allergies require an EPIPEN injection?	
☐	☐	Is insulin required and carried by youth?	
☐	☐	Is an inhaler required and carried by youth?	
		Date of last Tetanus booster: (mm/dd/yy)	

Name of Insurance Co.: _____ **Policy #:** _____

Medications camper will be taking during event/camp:

Medication #1	Reason	Dosage (mg)	Times of day given	Prescribing Physician & Phone Number

Describe side effects (mood/behavior changes, upset stomach, diarrhea):

List any special instructions or additional information regarding the medication that would be helpful to the health care staff:

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Participant Name: _____

Parent/Guardian Signature: _____

Medication #2	Reason	Dosage (mg)	Times of day given	Prescribing Physician & Phone Number
Describe side effects (mood/behavior changes, upset stomach, diarrhea): List any special instructions or additional information regarding the medication that would be helpful to the health care staff:				

Medication #3	Reason	Dosage (mg)	Times of day given	Prescribing Physician & Phone Number
Describe side effects (mood/behavior changes, upset stomach, diarrhea): List any special instructions or additional information regarding the medication that would be helpful to the health care staff:				

Medication #4	Reason	Dosage (mg)	Times of day given	Prescribing Physician & Phone Number
Describe side effects (mood/behavior changes, upset stomach, diarrhea): List any special instructions or additional information regarding the medication that would be helpful to the health care staff:				

Programs may have limited over-the-counter medications available. Select medications that can be administered, if available.

Acetaminophen (Tylenol): ☐Yes ☐No

Hydrocortisone (anti-itch) cream: ☐Yes ☐No

Benadryl: ☐Yes ☐No

Ibuprofen: ☐Yes ☐No

CONSENT FOR MEDICATION ADMINISTRATION AND MEDICAL TREATMENT

TO THE PARENT(S) OR LEGAL GUARDIAN:

If your son, daughter, or ward will be under the age of 18 while participating in a University of Wisconsin – Extension event/camp/program, it is event/camp/program policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device must be administered by designated event/camp/program health staff with the exception that a limited amount of medication for life-threatening conditions may be carried and administered by my son/daughter/ward (i.e. bee sting kit, inhaler, insulin syringe).

It is event/camp policy to secure your consent for medication distribution and for the use of medical devices by signing below.
Please check all that apply:

Yes	No		
☐	☐	No medication(s) has been brought to event/camp.	
☐	☐	Prescription medication(s) has been brought to event/camp. All prescription medication must be in the original medicine bottle and labeled with the youth participant's name, doctor's name, medication name, dosage, prescription number, date prescribed, and instructions. Also, information about any prescription medications must be provided in writing to event/camp health staff with the information requested in the later section of this form.	
☐	☐	Over-the-counter medications have been brought to event/camp and may be administered by event/camp health staff as needed. All over-the-counter medications must be labeled with the youth participant's name, medication name, dosage and instruction.	

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,

- I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- I am stating that I am aware of and accept the risk inherent in the program activity.
- I attest that all information on this form is correct and up-to-date, and that I will provide any and all significant material, and important changes to any information in this form to event/camp staff no later than check-in.
- I agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin –Extension, 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.

Participant Name (Please Print)

SIGNATURE OF PARENT OR LEGAL GUARDIAN **Date**

This is the approved health form for 4-H events and camps.

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