



Youth Health Form

Directions: Please complete this form. All participants must bring the form to the event. ALL Sections are REQUIRED. The following information must be filled in by the Parent/Guardian. Please provide complete information so we can be aware of your child's needs and provide appropriate care. Keep a copy of the completed form for your records.

Registration question please call 608.837.7328 between 8 a.m. and 4 p.m. Monday thru Friday.*

I. YOUTH CONTACT INFORMATION

Youth Name _____ Birth Date _____ Gender ____ Age ____
Last First Middle

Home Address _____
Street & Number City State ZIP

First Parent/Guardian _____ Email _____
 Phone: Home (____) _____ Cell (____) _____ Work (____) _____

Second Parent/Guardian _____ Email _____
 Phone: Home (____) _____ Cell (____) _____ Work (____) _____

If not available in an emergency, notify:

Name _____ Phone (____) _____ Alternate Phone (____) _____ Relationship: _____
 Name _____ Phone (____) _____ Alternate Phone (____) _____ Relationship: _____

II. CARE PROVIDERS

Name of family physician _____ Phone (____) _____
 Name of dentist/orthodontist _____ Phone (____) _____
 Medical/hospital insurance carrier _____ I have no medical/hospital insurance ____

Please attach copy of insurance card (both sides).

III. MEDICAL CONSENT AGREEMENT

Participant's Name: _____

CERTIFICATION AND CONSENT TO AUTHORIZE MEDICAL CARE FOR MINOR.

By signing below I, the undersigned, am stating that I have legal custody of the youth whose name is set forth above. I, the undersigned, hereby grant my authorization and consent to The Wisconsin Annual Conference of The United Methodist Church and The Wisconsin Conference Board of Trustees of The United Methodist Church, Inc., and their employees, clinicians, trainers, nurses, or agents, to administer first aid treatment for any minor injuries or illnesses and, if the injury is life threatening or in need of emergency treatment, to seek, approve, and obtain any medical, dental or surgical diagnosis, treatment or care for the youth including, but not limited to, x-ray, anesthetic, injections, medications, blood transfusions, and hospitalization, which is deemed advisable by, and is to be rendered under the general supervision of a physician, surgeon, dentist, hospital or other medical professional or institution. I authorize the release of any and all medical records concerning the youth to any health care provider authorized to provide care or treatment pursuant to this Medical Consent Agreement. I, the undersigned, agree to assume financial responsibility for all expenses of such care. I, the undersigned, have read, and I understand, all of the provisions of this Agreement.

 Parent or Guardian's Signature Date Participant's Signature Date

 Parent or Guardian's Name (Printed) Participant's Date of Birth

IV. HEALTH HISTORY:

Height: _____ Weight: _____ Date of Last Medical Exam: _____

Has your child experienced, or is currently experiencing, any of the following conditions?

- | | Yes/No | | Yes/No |
|---|---|--|---|
| 1. Recent injury, illness or infectious disease? | <input type="checkbox"/> <input type="checkbox"/> | 17. Back problems?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Chronic or recurring illness/condition?..... | <input type="checkbox"/> <input type="checkbox"/> | 18. Joint problems? | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Ever been hospitalized? | <input type="checkbox"/> <input type="checkbox"/> | 19. Wears a removable orthodontic appliance? | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Ever had any operations?..... | <input type="checkbox"/> <input type="checkbox"/> | 20. Skin problems? | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Frequent headaches? | <input type="checkbox"/> <input type="checkbox"/> | 21. Diabetes? | <input type="checkbox"/> <input type="checkbox"/> |
| 6. A head injury?..... | <input type="checkbox"/> <input type="checkbox"/> | 22. Asthma/Inhaler? | <input type="checkbox"/> <input type="checkbox"/> |
| 7. Knocked unconscious?..... | <input type="checkbox"/> <input type="checkbox"/> | 23. Mononucleosis in the past 12 months? | <input type="checkbox"/> <input type="checkbox"/> |
| 8. Wear glasses, contacts, or protective eye wear? | <input type="checkbox"/> <input type="checkbox"/> | 24. Problems with diarrhea/constipation? | <input type="checkbox"/> <input type="checkbox"/> |
| 9. Frequent ear infections? | <input type="checkbox"/> <input type="checkbox"/> | 25. Sleepwalking? | <input type="checkbox"/> <input type="checkbox"/> |
| 10. Passed out during or after exercise? | <input type="checkbox"/> <input type="checkbox"/> | 26. If female, abnormal menstrual history?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 11. Been dizzy during or after exercise? | <input type="checkbox"/> <input type="checkbox"/> | 27. History of bed-wetting?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 12. Had seizures? | <input type="checkbox"/> <input type="checkbox"/> | 28. Ever had an eating disorder?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 13. Had chest pain during or after exercise? | <input type="checkbox"/> <input type="checkbox"/> | 29. ADD/ADHD?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 14. Had high blood pressure?..... | <input type="checkbox"/> <input type="checkbox"/> | 30. Speech challenges?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 15. Bleeding/clotting disorder? | <input type="checkbox"/> <input type="checkbox"/> | 31. Ever had emotional difficulties for which
professional help was sought? | <input type="checkbox"/> <input type="checkbox"/> |
| 16. Diagnosed with a heart murmur?..... | <input type="checkbox"/> <input type="checkbox"/> | | |

Please explain "yes" answer(s) from above, noting the number of the question(s).

Please share any other information about the participant's behavior and physical, emotional, or mental health that may be helpful to our staff in meeting the needs of your youth.

V. RESTRICTIONS

The following **dietary** restrictions apply to this individual:

Explain any **activity** restrictions (e.g., what cannot be done, what adaptations or limitations are necessary).

VI. IMMUNIZATION HISTORY

* To protect the health of those who are medically unable to receive immunizations, we encourage youth to be vaccinated prior to the start of the event.

Please give all dates of immunizations: you may attach a record from your doctor or the state health department.

	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
Tetanus	_____	_____	_____	_____	_____	_____
DTP	_____	_____	_____	_____	_____	_____
TD (Tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
or Measles	_____	_____	_____	_____	_____	_____
or Mumps	_____	_____	_____	_____	_____	_____
or Rubella	_____	_____	_____	_____	_____	_____
Haemophilus InfLuenza B (<i>Hib B</i>)	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (Chicken pox)	_____	_____	_____	_____	_____	_____

If your child has not been fully immunized, please explain: _____

Which of the following diseases has the participant had?

- | | | | |
|--------------------------------------|---|--------------------------------------|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> German Measles |

VII. ALLERGIES

Please list all known Allergies. Describe reaction and management of the reaction.

Medication:

_____	_____
_____	_____
_____	_____

Food:

_____	_____
_____	_____
_____	_____

Insect stings/Bees:

_____	_____
_____	_____
_____	_____

Other:

_____	_____
_____	_____
_____	_____
_____	_____

VIII. MEDICATION AUTHORIZATION

Youth Name: _____ Birth Date: _____

I approve the administration of the following over-the-counter medications by the staff as needed:

- Ibuprofen and/or Acetaminophen (Tylenol) for headache, minor discomfort or fever
- Hydrocortisone cream and/or Benadryl for itching/discomfort caused by irritants and/or allergies.
- Insect Repellent
- Sunscreen

I am sending the following Prescription and/or over-the-counter Medications with my child:

Please keep all medications (prescription or over-the-counter) in original containers.

ALL medications should be listed on this form and clearly labeled with:

1) Youth name; 2) Name of medication; 3) Dosage; 4) Frequency of administration; 5) Method of administration;
and

If the medication has been prescribed by a physician, the label *must* also include:

6) Name of prescribing physician; 7) Prescription number; 8) Date prescribed; 9) Possible adverse reactions; 10) Specific conditions when contact should be made with physician; 11) Other special instructions:

Name of Medication _____ Date Prescribed: _____

Dosage: _____ Frequency: _____ Method of Administration: _____

Possible Side Effects: _____

Special Instructions: _____

Why has this medication been prescribed? _____

Contact the Physician When: _____

Name of Medication _____ Date Prescribed: _____

Dosage: _____ Frequency: _____ Method of Administration: _____

Possible Side Effects: _____

Special Instructions: _____

Why has this medication been prescribed? _____

Contact the Physician When: _____

Name of Medication _____ Date Prescribed: _____

Dosage: _____ Frequency: _____ Method of Administration: _____

Possible Side Effects: _____

Special Instructions: _____

Why has this medication been prescribed? _____

Contact the Physician When: _____

*** Please add additional pages as needed.

IX. PICK-UP AUTHORIZATION

_____ is authorized to pick up _____ at the conclusion of the event.
(Name of person authorized to pick up Youth) (Youth Name)

(Signature of Parent/Guardian)

(Date)