UW–MADISON EXTENSION

2023-2024 Youth Event Health Form

Event Name: _____

Dates: _____

Youth Name: _____ Birth date __/__/____ Age on 1st day of event _____ 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)	Yes	No	Allergies (check)	List specifics
☐	☐	Asthma	☐	☐	Insect stings	
☐	☐	Diabetes	☐	☐	Foods	
☐	☐	Epilepsy	☐	☐	Medications	
☐	☐	Psychiatric	☐	☐	Other	
☐	☐	Cognitive/Developmental	☐	☐	Do any allergies require an EPIPEN injection?	
☐	☐	Any dizziness, light-headedness or fainting associated with exercise within the past year?	☐	☐	Is insulin required and carried by youth?	
☐	☐	Any unexplained, rapid or irregular heart beat within the past year?	☐	☐	Is an inhaler required and carried by youth?	
☐	☐	A physician has sometime denied or restricted participation in sports due to a heart problem.	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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Youth Event Health Form (Continued)

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:

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

Accommodations

Does the youth require an accommodation to participate in this event? Please describe:

Please describe any limitations or restrictions regarding the youth's participation:

Is there any other information you want to share?

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 – Madison Division of 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		
☐	☐	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 – Madison Division of 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.

Wisconsin 4-H Camp Health Form Addendum

UW–MADISON EXTENSION

Event Name: _____

Dates: _____

Participant Name: _____ Birth Date: _____

Parent/Guardian: _____ E-mail address: _____

Phone Numbers: Home _____ Phone Numbers: Cell _____

IMMUNIZATIONS

List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE (√) OR (X) except to answer the question about chickenpox, Tdap or Td. If you do not have an immunization record for this child at home, contact your doctor or public health department to obtain it. A copy of the child's complete immunization record from the WIR may be attached to this form http://www.dhfswir.org or from healthcare providers, state, or local government are also acceptable.

TYPE OF VACCINE*	FIRST DOSE Mo/Day/Yr	SECOND DOSE Mo/Day/Yr	THIRD DOSE Mo/Day/Yr	FOURTH DOSE Mo/Day/Yr	FIFTH DOSE Mo/Day/Yr
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio (IPV)					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine Vaccine is needed only if your child has not had Chickenpox disease.			Has your child had Varicella (chickenpox) disease? ☐ Yes, year: ☐ No or Unsure (vaccine needed)		

☐ For health reasons, this child is not fully immunized.
☐ For personal conviction or religious reasons, this child is not fully immunized. **Include any immunizations received above.*

ADDITIONAL MEDICATIONS NOT PREVIOUSLY LISTED

☐ This participant will take the following medication(s) while attending camp. I am bringing enough medication to last the entire session and it is in the original container labeled by the pharmacy. (If more space for medications is needed, staple another page with additional medications to the end of the form.)

Name of Medication	Amount or Dose Given	Reason for Taking It	When It Is Given	How It Is Given	Emergency Medication Only Legal Guardian to initial below if camper is **able to carry and self-administer** (i.e inhaler, epi-pen)
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		

SIGNATURE

This health history is correct and accurately reflects the health status of the participant. The person described has permission to participate in all event activities except as noted by me or an examining physician. I give permission to the event to provide routine healthcare services, administer medications, and seek emergency services.

_____ _____

SIGNATURE – Parent/Guardian/Legal Custodian DATE