

Name: \_\_\_\_\_  
(Print Last Name) (Print First Name)

# YOUTH HEALTH INFORMATION & CONSENT FOR EMERGENCY TREATMENT

## Burnett County UW-Extension 4-H Youth Development Programs

Trip/Activity: \_\_\_\_\_ Dates: \_\_\_\_\_

This information is confidential and necessary for proper care by staff advisors and medical personnel.

Information must be legibly printed in black ink or typed.

Do not leave empty blanks; enter N/A if not applicable. Incomplete forms will be returned!

### Participant Information:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  Female  Male

**Health:** Has this delegate experienced any of the following illnesses/injuries/diseases/disorders/problems or symptoms? If you check "yes" to any of the following, *enter the details below* including diagnosis, treatment, date of illness or injury, name of hospital, name of physician and telephone number. Continue on reverse side of page, if necessary.

Yes	No	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to bee stings. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to dyes (red dye, food coloring). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to environmental factors (pollen, mold, dust, hay fever). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to foods. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to latex. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medicines including penicillin, tetanus, etc. Explain _____
		How does this person react to the(se) allergy(ies)? _____
		Normal treatment? _____
<input type="checkbox"/>	<input type="checkbox"/>	Bladder or bowel control, bedwetting. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or hypoglycemia (low blood sugar). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorders (anorexia, bulimia or other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Emotional or mental (sever homesickness, reaction to stress, frequent anxiety, excessive fears, etc.). Explain concern and suggested method of handling it _____
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to a contagious or serious disease recently. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Eye or ear (color blindness, peripheral vision, depth perception, near or farsightedness, ear infection, impaired hearing or other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart (high/low blood pressure, murmurs, chest pains, rheumatic fever, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or gall bladder. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Learning or attention disorders. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Limiting physical conditions (sitting, standing, walking). Is special equipment or assistance needed? Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal (arthritis, recent fractures, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Nervous system (convulsions, epilepsy, dizziness, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Nose or throat (thyroid, lymph nodes, carotid arteries, other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Reproductive (menstrual difficulties, other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory (asthma, persistent/chronic cough, abnormal chest x-ray, tuberculosis, or any other lung problems). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Skin (rash, other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Sleep (sleepwalking, recurrent nightmares, other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach, liver or intestinal (ulcers, jaundice, hernia, colitis, indigestion, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Surgical operations, accidents or injuries in the past 2 years. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Vascular and blood (anemia; Hepatitis B or C; hemophilia, HIV positive; HBV; migraines, nosebleeds, transfusions, unconsciousness/fainting, other). Explain _____

**Continued explanations of "yes" answers:**

**Other important health information** that the adult advisors should know? \_\_\_\_\_

**Contagious diseases:** list dates of exposure and occurrence of the following: Measles, Mumps, Rubella, Chicken Pox, Mononucleosis, Tuberculosis, Pneumonia \_\_\_\_\_

**Dietary needs/restrictions:**  
List special dietary needs or restrictions: \_\_\_\_\_

**General attitude/mood/alertness** (shyness, energy level, cooperation): \_\_\_\_\_

**Immunizations – list dates of last vaccines:**  
Hepatitis \_\_\_\_\_ Influenza \_\_\_\_\_ Tetanus \_\_\_\_\_ MMR (Measles/Mumps/Rubella) \_\_\_\_\_

Was this a second MMR immunization? \_\_\_\_\_

**Medications:**  
List all prescription/non-prescription medications participant will require during the program, listing dosages, time medications are taken, and sensitivity to them: \_\_\_\_\_

Do you want an adult to collect and dispense medications?  Yes  No

**Social habits** (smoking or chewing tobacco, alcohol consumption, illicit drug use). Explain: \_\_\_\_\_

**Insurance information:**  
Insurance Co. \_\_\_\_\_ Policy Number \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_

**Physician information:**  
Family Physician or Clinic \_\_\_\_\_ Phone \_\_\_\_\_  
Date of Last Medical Exam \_\_\_\_\_ Is participant under a doctor's care now?  Yes  No

**Parent/Guardian information:**  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
Day Phone (\_\_\_\_) \_\_\_\_\_ Evening Phone (\_\_\_\_) \_\_\_\_\_

**Alternate contact in case of emergency:**  
Name \_\_\_\_\_ Relationship to Participant \_\_\_\_\_  
Day Phone (\_\_\_\_) \_\_\_\_\_ Evening Phone (\_\_\_\_) \_\_\_\_\_

*I understand that failure to provide complete information on this health form could hinder chaperones' and staff's ability to provide adequate care and could result in termination of my son/daughter's participation in this event.*

*I am of the opinion that \_\_\_\_\_ can safely participate in this program. I consider his/her health to be:*  
 Excellent  Good  Fair  Poor. *I further declare that he/she has no physical, mental, or communicable conditions that will interfere with participation in this program.*

I will notify the Burnett County UWEX 4-H Youth Development Office of any changes in health or prescriptions between now and departure. I understand my son/daughter will be supervised and that if a serious illness or injury develops, medical and/or hospital care will be given but UWEX, 4-H Youth Development and program/volunteer staff are not responsible in case of accidental injury or illness. I or the person noted above will be notified as soon as possible in case of medical emergency while my son/daughter is participating in this program. If a medical emergency arises, I give permission for emergency treatment or surgery as recommended by an attending physician. I agree to cover cost of prescriptions and emergency transportation to medical facilities or home, if necessary.

Signature or Parent/Gaurdian \_\_\_\_\_ Date \_\_\_\_\_

Return form to: UW-Extension Burnett County  
7410 County Rd. K #107  
Siren, WI 54872