Wisconsin Conference
of The United Methodist Church

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
1. Recent injury, illness or infectious disease?	□	□
2. Chronic or recurring illness/condition?	□	□
3. Ever been hospitalized?	□	□
4. Ever had any operations?	□	□
5. Frequent headaches?	□	□
6. A head injury?	□	□
7. Knocked unconscious?	□	□
8. Wear glasses, contacts, or protective eye wear?	□	□
9. Frequent ear infections?	□	□
10. Passed out during or after exercise?	□	□
11. Been dizzy during or after exercise?	□	□
12. Had seizures?	□	□
13. Had chest pain during or after exercise?	□	□
14. Had high blood pressure?	□	□
15. Bleeding/clotting disorder?	□	□
16. Diagnosed with a heart murmur?	□	□
17. Back problems?	□	□
18. Joint problems?	□	□
19. Wears a removable orthodontic appliance?	□	□
20. Skin problems?	□	□
21. Diabetes?	□	□
22. Asthma/Inhaler?	□	□
23. Mononucleosis in the past 12 months?	□	□
24. Problems with diarrhea/constipation?	□	□
25. Sleepwalking?	□	□
26. If female, abnormal menstrual history?	□	□
27.History of bed-wetting?	□	□
28. Ever had an eating disorder?	□	□
29. ADD/ADHD?	□	□
30. Speech challenges?	□	□
31. Ever had emotional difficulties for which professional help was sought?	□	□

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 or your youth.

_____

_____

_____

V. RESTRICTIONS

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

_____

_____

_____

Explain any **activity** restrictions *(e.g., what cannot be done, what adaptions 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 *(Hlb B)*						
Hepatitis B						
Varicella (Chicken pox)						

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

Which of the following diseases has the participant had?

□ Measles	□ Whooping Cough	□ Chicken Pox	□ Mumps
□ Hepatitis A	□ Hepatitis B	□ Hepatitis C	□ 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)