University of Wisconsin – Sheboygan
2014 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

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 at the University of Wisconsin – Sheboygan, it is event/camp policy to secure your consent for **medication distribution and for the use of medical devices**. The medication or medical device can be self-administered or be administered by designated event/camp health staff with the exception that controlled drugs (i.e. Codeine, Ritalin, Adderall, Dexedrine, etc.) must, by law, be administered by event/camp health staff.

All prescription medication must be in the **original medicine bottle** (see picture at right) and labeled with the youth participant's name, doctor's name, medication name, dosage, prescription number, date prescribed, and instructions. You must also complete the form below:

☐ No medication(s) has been brought to event/camp.

☐ I want the medication or medical devices self-administered (age 14 and above only).
☐ I give permission for my child to receive Tylenol or Pepto Bismol if needed.
☐ I want the medication or medical device administered by the designated health care staff. However, a limited amount of medication for life-threatening conditions may be carried by my son/daughter/ward (i.e. bee sting kit, inhaler, insulin syringe).

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 both sides of this form is correct.
- give my permission for my child's photo to be taken and used for marketing and informational purposes.
- I understand University employees are mandatory reporters of child abuse and neglect.
- I agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin –Sheboygan, 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**

(Must Complete Consent Form and Reverse Side)

UW -Sheboygan
Youth Event Health Form (Continued)

Participant Name: _____
Parent/Guardian Signature: _____

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

Allergies (check & list specifics)

- ☐ Insect stings _____
- ☐ Foods _____
- ☐ Medications _____
- ☐ Other _____

Do any allergies require an EPIPEN Injection? ☐ Yes ☐ No
Is an inhaler required and carried by youth? ☐ Yes ☐ No
Date of last Tetanus booster : _____

Name of Insurance Co.: _____ Policy #: _____

Description of any limitation or restriction of event activities:

_____

Any special accommodations regarding physical or emotional conditions that we need to be aware of regarding your child's participation in this event/camp (include circumstances when physician should be notified)?

_____

Medications camper will be taking at camp:

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

1. Does the youth experience any side effects from the medication? (i.e., mood/behavior changes, upset stomach, diarrhea) ☐ Yes ☐ No

_____

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

2. _____

***** <u>FOR EVENT/CAMP USE ONLY</u> – TO BE COMPLETED BY HEALTH CARE STAFF AT CHECK-IN *****

1. Are there any changes in your child's health status since the medical forms were sent in? ❑ No ❑ Yes
2. Has your child, or anyone in your family been sick or exposed to any communicable disease in the past month? ❑ No ❑ Yes
3. Does your child now have any rashes or open sores? ❑ No ❑ Yes
4. Are there any changes in your dependent's medications? *(If **Yes**, Staff make changes . & sign)* ❑ No ❑ Yes
5. Does your child have any recent injury or activity restrictions? ❑ No ❑ Yes
6. Will the custodial parent(s) or guardian be available at the numbers listed on this form during the camping session? ❑ No ❑ Yes
   If NO, list the name & phone number of person(s) authorized to make decisions on their behalf if different than the emergency contact listed on the reverse side of this form:

_____

Information provided by: _____ **To:** _____ **Date:** _____

(Must Complete Consent Form and Reverse Side)