University of Wisconsin–Stout
2016 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 _____

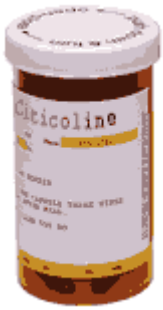
Address:_____
Street City State Zip

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–Stout, it is event/camp 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 health staff with the exception that 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).

☐ Prescription medication(s) has been brought to event/camp. 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. Also, information about any prescription medications must be provided in writing to event/camp health staff with the information requested on the second page of this form.



☐ Over-the-counter medications have been brought to event/camp and may be administered by camp health staff as needed. All over-the-counter medications must be labeled with the youth participant's name, medication name, dosage, and instruction.

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

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 agreement to **all of the following** statements. 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 and up-to-date, and that **I will provide any and all significant, material, or 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-Stout, 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.
- In the event that outside medical treatment is sought while my child/ward is a camp participant, and the child/ward is returned to camp following the medical treatment, I hereby give permission for UW-Stout to obtain medical records and medical information from and disclose such information to any medical facility my child/ward would be taken to. Information disclosed may be verbal or written and relate only to the injury/illness that the camp participant is currently being treated for.

_____

Participant Name (Please Print)

_____

SIGNATURE OF PARENT OR LEGAL GUARDIAN **Date**

(Must complete reverse side)

UW Stout
Youth Event Health Form (Continued)

Participant Name:_____
Parent/Guardian Signature:_____

Health Conditions (check)

- ☐ Asthma Insect stings
- ☐ Diabetes Foods
- ☐ Epilepsy Medications
- ☐ Psychiatric Other
- ☐ 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: _____
**You may also attach an updated Immunization Record*

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

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

***** FOR EVENT/CAMP USE ONLY – 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:**_____

Risk Awareness Agreement

The undersigned does hereby agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, its 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 the undersigned in the course of participating in _____.

The undersigned acknowledges that they understand that:

1. Risk is involved in participating in this event.
2. They understand the university will not provide medical coverage.
3. They understand the university will not provide liability coverage.
4. They have their own health insurance.

_____

Print Name of Participant

_____ _____

Print Name of Parent/Guardian Date

_____ _____

Signature Date

Camp/Clinic
Concussion/Head Injury Form

I have received and read the concussion and head injury information sheet. I understand that there is a risk of injury during athletic participation and I agree to disclose any signs and symptoms of a concussion to the camp coaching staff. I also understand that I will be removed from play to eliminate the risk of further injury and will not be able to resume participation until evaluated and cleared by a member of the camp health services staff who has experience with evaluating and managing pediatric concussions and head injuries.

I understand that this is in accordance with the State of Wisconsin Youth Concussion Law.

_____ _____

Participant's Signature Participant's Name (Print)

_____ _____

Parent/Guardian (if participant is under 19) Date

Camp Name:_____ Camp Date:_____