UNIVERSITY of LOUISIANA LAFAYETTE

Youth Program Participant Health History Form (page 1)

Dates will attend Youth Program: from_____ (Month/Day/Year) to _____ (Month/Day/Year)

Participant Name: _____ (First) (Middle) (Last)

☐ Male ☐ Female Birth Date_____ (Month/Day/Year) Age on arrival at camp: _____

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) ***Complete pages 1& 2 of this form and make a copy.***
2) ***Send the original, signed FORM by the requested date.***
3) ***Complete the top of FORM 2 (PARTICIPANT HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to the Participant's health-care provider for review and completion.***
4) ***After it has been completed and signed by the Participant's health-care provider, return FORM 2 to Youth Program by the requested date.***

Participant Home Address: _____ (Street Address) (City) (State) (Zip Code)

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name:_____ Relationship to Participant:_____ Preferred Phones: (_____)_____(_____)_____

Email: _____

Home Address: _____ (If different from above) (Street Address) (City) (State) (Zip Code)

Second parent/guardian or other emergency contact:

Name:_____ Relationship to Participant:_____ Preferred Phones: (_____)_____(_____)_____

Email: _____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name:_____ Relationship to Participant:_____ Preferred Phones: (_____)_____(_____)_____

Allergies: ☐ No known allergies. ☐ This Participant is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other

Please describe below what the Participant is allergic to, and the reaction symptoms:

Diet, Nutrition: ☐ This Participant eats a regular diet. ☐ This Participant eats a regular vegetarian diet. ☐ This Participant is lactose intolerant.
☐ This Participant is gluten intolerant.
☐ Other, ***please explain:***

Restrictions: ☐ I have reviewed the Youth Program and activities of the Youth Program and feel the Participant can participate without restrictions.
☐ I have reviewed the Youth Program and activities of the Youth Program and feel the Participant can participate with the following restrictions or adaptations.

Please describe restrictions or adaptions:

Medical Insurance Information:

This Participant is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number (_____)_____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the Participant to whom it pertains. The person described has permission to participate in all Youth Program activities except as noted by me and/or an examining physician. I give permission to the physician selected by the Youth Program to order x-rays, routine tests, and treatment related to the health of the Participant for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this Participant. I understand the information on this form will be shared on a "need to know" basis with Youth Program staff. I give permission to photocopy this form. In addition, the Youth Program has permission to obtain a copy of Participant's health record from providers who treat the Participant, and these providers may talk with the Youth Program's staff about the Participant's health s t a t u s .

Signature of Custodial Parent/Guardian_____ Date:_____ Relationship to Participant: _____

Participant Name_____ (First) (Middle) (Last)

(For Youth Program Use) Group_____ (For Youth Program Use) Session Code(s): _____

YOUTH PROGRAM PARTICPANT HEALTH HISTORY FORM (page 2)

Participant Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Medication: ☐ This Participant will not take any daily medications while attending Youth Program.

☐ This Participant will take the following daily medication(s) while at Youth Program:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review the Youth Protection Policy about medication administration. Original pharmacy containers with labels will be required which show the Participant's name and how the medication should be given for all prescription medications. Prescription medications require a completed medication order from an authorized prescriber in the state of Louisiana or adjacent state. Provide enough of each medication to last the entire time the Participant will be at the Youth Program.***

The following non-prescription medications may administer to manage illness and injury. If the Participant will be using any of the sample medications below, please include these in the list of medications below.

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Emilite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kao pectate/Pepto-Bismol)

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the Participant:

1. Ever been hospitalized? ☐ Yes ☐ No
2. Ever had surgery? ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? ☐ Yes ☐ No
4. Had a recent infectious disease? ☐ Yes ☐ No
5. Had a recent injury? ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath? ☐ Yes ☐ No
7. Have diabetes? ☐ Yes ☐ No
8. Had seizures? ☐ Yes ☐ No
9. Had headaches? ☐ Yes ☐ No
10. Had fainting or dizziness? ☐ Yes ☐ No
11. Passed out/had chest pain during exercise? ☐ Yes ☐ No
12. Had mononucleosis during the past 12 months? ☐ Yes ☐ No
13. Have any skin problems? ☐ Yes ☐ No
14. Have problems with falling asleep/sleepwalking? ☐ Yes ☐ No
15. Ever had back/joint problems? ☐ Yes ☐ No
16. Traveled outside the country in the past 9 months? ☐ Yes ☐ No
17. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement. Has the Participant:

1. Ever been treated for an emotional difficulty such as anxiety or depression? ☐ Yes ☐ No
2. Ever been treated for a neurodevelopmental difficulty such as autism? ☐ Yes ☐ No
3. Ever been treated for an eating disorder? ☐ Yes ☐ No
4. Currently taking any medication to stabilize mood or behavior? ☐Yes ☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. The Youth Program may contact you for additional information.

Signature of Healthcare Provider _____ **Date** _____