

Please return this form with event registration and provide any changes to this form to event health personnel upon participant's arrival. Provide complete information so that the staff can be aware of your needs.

Name		First		Middle	
Home address	et address				
<del></del>	et address	City Age at ever	nt	State	Zip
Custodial parent/guardian	Name		Phone		
Home address (if different from above)					
	Street address	·	Other (	State	Zip
Second parent or guardian or emergency	contact	M	me		
Address	City				
Street address  If not available in an emergency, notify		State Zip			
		Name			
Relationship Phone	Address	Street address	City	Sta	ate Zip
Insurance Information: Is the participant c	overed by family medical/ho	spital insurance? 🔲 Ye	es 🛭 No		
If so, indicate carrier or plan name			Group	#	
Insurance carrier address			Phone number _		
Medication allergies (list) Food allergi	es (list) Other alle	ergies (list) – include inse	ect stings, hay fe	ver, asthma, a	animal dander, etc
Does not eat: ☐ Red meat ☐ Pork ☐ I	Dairy products	☐ Seafood ☐ Eggs	Other (descri	be)	
Permissions: My child ☐ has my ☐ has my	permission does not hence participate in the following the will be made to provide lived. I understand the ersity, its Board of the are not liable in case ther understand that in notified. If it is impossible or emergency treatment	ave my permission to att	rticipate in swim  care, administer medical treatmer e to the release ing, or insurance e necessary rela not be reached physician select	prescribed mat including or of any record purposes. I geted transportain an emerge ted by the car	rdering x-rays s necessary for give permission ation for me/my ncy, I hereby mp to secure
This health history is correct and complet the person herein described has permissi activities except as noted. I hereby give p  Signature of parent	e as far as I know, and on to engage in all camp ermission to the camp to	named above. This co out of camp.	mpleted form ma	ay be photoco	opied for trips
I also understand and agree to abide by a					
Signature of camper/staffer			Date		

## **Medications Being Taken:** Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time of this event. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. ☐ This person **takes NO medications** on a routine basis. OR ☐ This person **takes medications** as follows: \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_ Reason for taking \_\_\_\_\_ Med #1 \_\_\_ \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_ Reason for taking \_\_\_\_\_ Med #2 \_\_\_ Attach additional pages for more medications. Identify any medications taken during the school year that participant does/may not take during the summer. **General Questions:** (Explain "yes" answers below.) Has/does the participant: Yes Nο Yes Nο 16. Ever had back problems? 1. Had any recent injury, illness, or infectious disease? 17. Ever had problems with joints (e.g., knees, ankles)? 2. Have a chronic or recurring illness/condition? 18. Have an orthodontic appliance being brought to 3. Ever been hospitalized? ā 4. Ever had surgery? 19. Have any skin problems (e.g., itching, rash, acne)? 5. Have frequent headaches? 6. Ever had a head injury? 20. Have diabetes? 7. Ever been knocked unconscious? 21. Have asthma? 8. Wear glasses, contacts, or protective eye wear? 22. Had mononucleosis in the past 12 months? $\bar{\Box}$ $\overline{\Box}$ $\overline{\Box}$ 23. Had problems with diarrhea/constipation? 9. Ever had frequent ear infections? 24. Have problems with sleepwalking? 10. Ever passed out during or after exercise? 25. If female, have an abnormal menstrual history? 11. Ever been dizzy during or after exercise? 26. Have a history of bed-wetting? 12. Ever had seizures? 13. Ever had chest pain during or after exercise? 27. Ever had an eating disorder? 28. Ever had emotional difficulties for which professional 14. Ever had high blood pressure? help was sought? 15. Ever been diagnosed with a heart murmur? Please explain any "yes" answers, noting the number of the questions. Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should know. Name of family physician \_\_\_\_ Phone \_\_\_ Name of family dentist/orthodontist \_\_\_\_ Phone \_\_ Which of the following Please give all dates of immunization Mo/Yr Mo/Yr Mo/Yr has the participant had? Vaccine: Dates: Mo/Yr Mo/Yr Mo/Yr ■ Measles □ Diptheria ☐ Chickenpox ☐ Pertussis ☐ German measles □ Tetanus Polio ■ Mumps ☐ Hepatitis A ☐ Typhoid ☐ Hepatitis B ☐ Hepatitis C ☐ TB Mantoux Test ☐ Positive ☐ Negative Date of last test \_\_\_ Screening Record (For staff use only) Screened by \_\_

To request disability accommodations for state WVU Extension events, contact the Event Coordinator, 618 Knapp Hall, PO Box 6031, Morgantown, WV 26506-6031, phone (304) 293-2694, or fax (304) 293-7599. For local events, contact your county WVU Extension Office.

Updates/additions to health history noted ☐ Yes ☐ No ☐ None required

Date screened \_\_\_\_\_ Time \_\_\_\_ AM / PM

Current health needs identified \_\_\_\_\_

Meds received

Observational notes