EVENT NAME
PARTICIPANT HEALTHFORM

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Mail this form to the address below by (date)
Event Address

Attendance dates: from: _____ to _____

Participant Name: _____
First Middle Last

☐ Male ☐ Female Birth Date _____ Age on arrival at program ____
Month/Day/Year

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

1. ***Complete pages 1, 2 and 3 of this form (and make a copy for yourself).***
2. ***Send the original, signed form to program by requested date.***

Participant Home Address: _____
Street Address City State Zip Code

Parent/guardian with residential placement and/or decision-making authority in the event 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 with legal custody to be contacted in case of illness or injury:

Name:_____ Relationship to Participant: _____

Preferred Phones: (_____) _____ (_____) _____ Email: _____

Additional parent/guardian to be contacted in case of illness or injury:

Name:_____ Relationship to Participant: _____

Preferred Phones: (_____) _____ (_____) _____ Email: _____

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 seen, in detail. Please describe preventative or responsive measures.)
☐ **This participant has a life-threatening allergy. An emergency care plan signed by physician is required.**

Diet, Nutrition: ☐ This participant eats a regular diet. ☐This participant eats a vegetarian diet (describe details below).
☐ This participant has special food needs. ***(Please describe below.)***

Immunizations:

☐ My child is up-to-date on his/her immunizations and tetanus shots as required by Washington State law. Date of last Tetanus shot: _____

☐ My child has an immunization exemption on file with his/her school. I understand and accept the risks to my child from not being fully immunized.

Medication:

We will be unable to administer medication to children. If your child requires a dosage during activity/event hours, please make appropriate arrangements. Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **All medications must be in their original containers. Prescriptions must have the child's name and how the medication should be given printed on the prescription container. Please send only those medications that are necessary.**

Medications Currently being taken: (must list)

☐ This participant will not take any daily medications while attending the activities.

☐ This participant will be **self-administering** the following daily medication(s) while attending the activities.[1]

Participant Name: _____
First Middle Last

_____ (For Camp Use) Cabin or Group

_____ (For Program Use) Session Code(s)

[1] Note: These provisions regarding administration of medication shall not abrogate minors' rights to provide their own consent to certain services under Washington law.

EVENT NAME PARTICIPANT HEALTH FORM PAGE 2/2	Participant Name: _____ First Middle Last Birth Date: _____ Month/Day/Year

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

Has/does this 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. Has asthma/wheezing/shortness of breath?..... ☐ Yes ☐ No
7. Have diabetes?..... ☐ Yes ☐ No
8. Had seizures?..... ☐ Yes ☐ No
9. Had headaches?..... ☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No
11. Had fainting or dizziness?..... ☐ Yes ☐ No
12. Passed out/had chest pain during exercise?..... ☐ Yes ☐ No
13. Had mononucleosis ("mono") during the past 12 months?..... ☐ Yes ☐ No
14. Ever had back/joint problems?..... ☐ Yes ☐ No
15. Have problems with diarrhea/constipation?..... ☐ Yes ☐ No
16. Have any skin problems?..... ☐ Yes ☐ No
17. Traveled outside the country in the past 9 months?..... ☐ Yes ☐ No
18. Had Sickle Cell disease or traits?..... ☐ Yes ☐ No
19. Had high blood pressure? ..... ☐ Yes ☐ No
20. Had cardiovascular disease or other heart problems? ..... ☐ Yes ☐ No
21. Have a history of heart disease (not limited to conjunctive heart defect, cardiomyopathy, ahbrythemia?)..... ☐ 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.

Restrictions:

☐ I have reviewed the program and activities of the program and feel the participant can participate without restrictions.

☐ I have reviewed the program and activities of the program and feel the participant can participate with the following restrictions or adaptations. ***(Please describe below.)***

Does the participant require reasonable accommodation for a disability in order to access or be part of the activities?

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the participant's health that you think important or that may affect his or her ability to fully participate in the program. ***Attach additional information if needed.***

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 program activities except as set forth by me and/or an examining physician. If you fail to advise WSU of a medical condition, WSU is not responsible for related injuries. I understand the information on this form will be shared on a "need to know" basis with WSU staff and volunteers. I give permission to photocopy this form. In addition, the health care provider has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial _____ Relationship to Participant: _____

Parent/Guardian:_____ Date: _____ _____

Parent/Guardians: Keep a copy for your records.