

**Health History for Youth Participants of the
HULBERT OUTDOOR CENTER (to be completed every year)**

Program Name/Dates _____ **Gender:** () Male () Female

Name _____ **Birthdate** _____ **Age** _____
Last First Middle (MM/DD/YY)

Parent/Guardian:
Mr./Mrs./Ms. _____ **Email** _____

Check one: () Dad () Step-Dad () Mom () Step-Mom () Grandfather () Grandmother () Other: _____

Home Address _____ **Phone** _____
Street Address City State ZIP

Work # _____ **Cell #** _____ **Fax #** _____

Additional emergency contact _____ **Relationship** _____

Home # _____ **Work #** _____ **Cell #** _____

Insurance Is participant covered by medical/hospital insurance? () Yes () No

Name of Insurance _____ Name of Policy Holder _____

Policy Holder Employer _____ Policy Holder date of birth _____

Carrier Address _____ Phone _____

Group # _____ Certificate # _____

Immunization History: Provide the month and year for immunizations. Asterisked (*) immunizations must be current.

Immunization	Date — Month(s) & Year(s)	Immunization	Date — Month(s) & Year(s)
Tetanus Booster*	(Current within 10 years)	Polio*	
Varicella* (Chicken Pox)		MMR (Mumps, Measles, Rubella)*	
Meningitis		Pneumococcal	
Pertussis Booster (Whooping Cough)		DPT (diphtheria, tetanus, pertussis)*	
Hepatitis B		Hepatitis A	
Influenza			

Health History Questions (Explain "Yes" answers below.)

Has/does the participant: **Yes No**

- 1. Have a chronic or recurring illness/condition? () ()
- 2. Ever been hospitalized? () ()
- 3. Ever had surgery? () ()
- 4. Have frequent headaches? () ()
- 5. Ever had a head injury? () ()
- 6. Ever had frequent ear infections? () ()
- 7. Ever had seizures? () ()

- 8. Ever had chest pain during or after exercise? () ()
- 9. Ever had high blood pressure? () ()
- 10. Ever had problems with joints? () ()
- 11. Have any skin problems (e.g., itching, rash, acne)? () ()
- 12. Had mononucleosis in the past 12 months? () ()
- 13. Have problems with sleepwalking? () ()
- 14. Have an eating disorder? () ()
- 15. Ever had emotional difficulties for which professional help was sought? () ()

Please explain "Yes" answers, noting the number of the question.

Dietary Restrictions

- () Does not eat red meat () Does not eat pork () Does not eat eggs
- () Does not eat poultry () Does not eat seafood () Does not eat dairy products
- () Other (describe) _____

Activity Restrictions (e.g. what cannot be done, what adaptations or limitations are necessary).



Hulbert Outdoor Center - Youth Participant Name: _____

The intent of this information is to provide Hulbert Outdoor Center the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to Hulbert personnel upon participant's arrival. Provide complete information so Hulbert can be aware of participant needs.

ALLERGIES List all known. For all listed, describe reaction and management of the reaction.

Medication or other substances:

_____ This causes anaphylaxis? Yes No
_____ This causes anaphylaxis? Yes No
_____ This causes anaphylaxis? Yes No

Food:

_____ This causes anaphylaxis? Yes No
_____ This causes anaphylaxis? Yes No
_____ This causes anaphylaxis? Yes No

Other allergies - include insect stings, hay fever, asthma, animal dander, etc.

_____ This causes anaphylaxis? Yes No
_____ This causes anaphylaxis? Yes No
_____ This causes anaphylaxis? Yes No

MEDICATIONS

() This participant takes NO medications on a routine basis or () This participant will take the following medications:

Please list all medications (including non-prescription) which will be taken routinely at Hulbert.

Med #1 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____
Med #2 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____
Med #3 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which Hulbert should be aware.

Please list all healthcare providers currently treating participant.

Name of physician _____ **Phone** _____

Address _____

Name of dentist/orthodontist _____ **Phone** _____

Address _____

Names of additional healthcare providers (e.g. psychiatrist, homeopath, allergist, dermatologist)

Name _____ **Specialty** _____ **Phone** _____

Address _____

IMPORTANT - THIS BOX MUST BE COMPLETED FOR ATTENDANCE*

This health history is correct and complete as far as I know. Participant can engage in all activities, except as noted. In case a medical or surgical emergency occurs, I hereby give permission for medical intervention, and/or anesthesia and surgery, to be administered by appropriate medical personnel as designated by the Director of Hulbert Outdoor Center to participant. This form may be photocopied for trips away from Hulbert and information may be shared with staff, as needed.

Parent/Guardian Signature _____

Printed Name _____ Date _____

* If for religious reasons you cannot sign this, contact Hulbert Outdoor Center for a legal waiver which must be signed for participation.