Program Name: _____ Program Date(s):_____

HEALTH Form

PARTICIPANT INFORMATION

Participant Name: _____
First Middle Last

Sex_____ Birth Date _____ Age on arrival at program: _____
Month/Day/Year

EMERGENCY CONTACT INFORMATION

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

Name: _____ Relationship to Participant: _____

Home Address: _____

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

Please list two emergency contacts. Parent/Legal Guardian agrees that the Program has permission to contact the named emergency contacts in the event of an emergency or other appropriate circumstances and consents to the Participant being released to the custody and care of the emergency contact (if deemed necessary or appropriate by the Program) when Parent/Legal Guardian cannot be reached.

_____
Emergency Contact # 1 Name Home Phone Work Phone Cell Phone Relation

_____
Emergency Contact # 2 Name Home Phone Work Phone Cell Phone Relation

INSURANCE INFORMATION

Participant is required to be covered by U.S.-based medical insurance.

Policy Holder's (P.H.) Name: _____ P.H.'s Date of Birth: _____

P.H.'s Relation to Participant: _____ P.H.'s Address:_____

Insurance Company: _____ Insurance Phone Number: (_____)_____

Policy #: _____ Group #: _____

HEALTH HISTORY

Has Participant ever tested positive for Covid-19?

□ No □ Yes, and the date of the positive test was _____

Has Participant been vaccinated against Covid-19?

□ No □ Yes, and the date of the shot(s) was _____

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. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder? …… □ Yes □ No
10. Ever been treated for emotional or behavioral difficulties or an eating disorder? ……. □ Yes □ No
11. During the past 12 months, seen a professional to address mental/emotional health concerns? …….. □ Yes □ No
12. Had a significant life event that continues to affect the Participant's life? *(I.e. History of abuse, death of a loved one, family change, foster care, new sibling, survived a disaster, others)* ….. □ Yes □ No
13. Had headaches? ..... □ Yes □ No
14. Wear glasses, contacts, or protective eyewear?..... □ Yes □ No
15. Experienced fainting or dizziness? ..... □ Yes □ No
16. Passed out/had chest pain during exercise?..... □ Yes □ No
17. Had mononucleosis ("mono") during the past 12 months?..... □ Yes □ No
18. If female, have problems with periods/menstruation?. ..... □ Yes □ No
19. Have problems with falling asleep/sleepwalking? ..... □ Yes □ No
20. Ever had back/joint problems?… ..... □ Yes □ No
21. Have a history of bedwetting?…. ..... □ Yes □ No
22. Have problems with diarrhea/constipation?… ..... □ Yes □ No
23. Have any skin problems?… ..... □ Yes □ No
24. Traveled outside the country in the past 9 months?..... □ 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.

_____

_____

The Participant is undergoing treatment at this time for the following conditions:
(describe below) ☐ None.

_____

_____

ALLERGIES

□ No known allergies
□ To foods *(list)*:
□ To medications *(list)*:
□ To the environment *(insect stings, hay fever, etc.– list)*:
□ Other allergies *(list)*:
□ Dietary restrictions *(list)*:

Describe previous reactions

_____

_____

Explain/describe if Participant has a need for an EpiPen or Epinephrine

_____

_____

OTHER INFORMATION

Please provide in the space below any additional information about the Participant's health that you think important or that may affect the Participant's ability to fully participate in the program. Attach additional information if needed.

_____

_____

_____

ATTESTATION TO HEALTH INFORMATION

I certify that the above information is complete and accurate. I have reviewed and understand the program description and activities of the program and believe that Participant is physically and emotionally fit to participate in the Program without restrictions or adaptations, except as noted below:

_____

_____

□ Yes □ No