UW	/-M	ADISON EXTENSION 2024 Youth Ex ADISON EXTENSION	-	nt I	Iealth		ent Name: Dates:	Buffalo Summer	· 2024
You	th Na	ame:Birth date	/	/	Age on 1 <sup>s</sup>	<sup>st</sup> day o	f event	Sex:	Male Female
Cust	odia	Parent/Guardian (or spouse)				E-mai	l address:		
Phone Numbers: Home () Work () Cell phone ()							_		
Uon	a ad	dragg							
поп	ie au	dress: Street	(	City State 2			Zip		
Seco	nd n	arent/guardian		5					Ĩ
	-	nergency contact:				Pho	ne: Home (	)	<u>-                                     </u>
								)	
							work (_	)	
Add	ress:	Street		City			0		7.
		Street	,	Сцу			3	tate	Zip
Yes	No	Health Conditions (check)	Yes	No	Allergies (cl	neck)	List specific	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	
	$\square$	Asthma	$\square$	$\square$	Insect stings	iccky	List speen		
		Diabetes			Foods				
		Epilepsy			Medications				
		Psychiatric			Other				
		Cognitive/Developmental			Do any aller	gies rec	quire an EPII	EN injection	1?
		Any dizziness, light-headedness or fainting associated							
		with exercise within the past year?			Is insulin rec	uired a	and carried by	y youth?	
		Any unexplained, rapid or irregular heart beat within the past year?			Is an inhaler	require	ed and carried	d by youth?	
		A physician has sometime denied or restricted participation in sports due to a heart problem.	Dat	e of l	ast Tetanus be	ooster:	(mm/dd/yy	)	
Name of Insurance Co.:							Policy #:		
	Medications camper will be taking during event/camp:								
<b></b>									

Medication #1	Reason	Dosage (mg)	Times of day given	Prescribing Physician & Phone Number			
Describe side effects (mood/behavior changes, upset stomach, diarrhea):							
List any special instructions of	or additional information	on regarding the me	dication that would be	helpful to the health care staff:			

# UW – Madison Extension Youth Event Health Form (Continued)

Participant Name: \_\_\_\_\_

Parent/Guardian Signature:

Medication #2	Reason	Dosage (mg)	Times of day given	Prescribing Physician & Phone Number
Describe side effects (mood/	behavior changes, upse	et stomach, diarrhea)	:	

List any special instructions or additional information regarding the medication that would be helpful to the health care staff:

Describe side effects (mood/behavior changes, upset stomach, diarrhea):							
List any special instructions or ad	List any special instructions or additional information regarding the medication that would be helpful to the health care staff:						

Programs may have limited	l over-the-counter	medications available. Select medications that can be administered, if available.
Acetaminophen (Tylenol):	Yes	No
Hydrocortisone (anti-itch)	cream: Yes	No
Benadryl: Yes	No	
Ibuprofen: Yes	No	

#### Accommodations

Does the youth require an accommodation to participate in this event? Please describe:

Please describe any limitations or restrictions regarding the youth's participation:

Is there any other information you want to share?

## CONSENT FOR MEDICATION ADMINISTRATION AND MEDICAL TREATMENT

#### TO THE PARENT(S) OR LEGAL GUARDIAN:

If your son, daughter, or ward will be under the age of 18 while participating in a University of Wisconsin – Madison Division of Extension event/camp/program, it is event/camp/program policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device must be administered by designated event/camp/program health staff with the exception that a limited amount of medication for life-threatening conditions may be carried and administered by my son/daughter/ward (i.e. bee sting kit, inhaler, insulin syringe).

It is event/camp policy to secure your consent for medication distribution and for the use of medical devices by signing below.

Please check all that apply:

Yes	No		
		Medication(s) has been brought to event/camp.	
		Prescription medication(s) has been brought to event/camp. All prescription medication must be in the original medicine bottle and labeled with the youth participant's name, doctor's name, medication name, dosage, prescription number, date prescribed, and instructions. Also, information about any prescription medications must be provided in writing to event/camp health staff with the information requested in the later section of this form.	Sticoline
		Over-the-counter medications have been brought to event/camp and may be administered by event/camp health staff as needed. All over-the-counter medications must be labeled with the youth participant's name, medication name, dosage and instruction.	

If your son, daughter, or ward will be under the age of 18 years while at the event/camp, it is our policy to secure your consent for **all of the following**. By signing below,

- I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- I am stating that I am aware of and accept the risk inherent in the program activity.
- I attest that all information on this form is correct and up-to-date, and that I will provide any and all significant material, and important changes to any information in this form to event/camp staff no later than check-in.
- I agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin Madison Division of Extension, their officers, agents, and employees from any and all liability, loss, damages, costs, or expenses which are sustained, incurred or required arising out of the actions of my son, daughter or ward in the course of the event/camp.

Participant Name (Please Print)

### SIGNATURE OF PARENT OR LEGAL GUARDIAN

Date

This is the approved health form for 4-H events and camps.