



# 2025-2026 Youth Event Health Form

Event Name: 4-H STEAM  
Adventure Days

UW-MADISON EXTENSION

Start Date: June 26th, 2026 &  
July 10th, 2026

Youth Name: \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age on 1<sup>st</sup> day of event \_\_\_\_\_ Sex:  Male  Female

Custodial Parent/Guardian (or spouse) \_\_\_\_\_ E-mail address: \_\_\_\_\_

Phone Numbers: Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Home address: \_\_\_\_\_  
Street City State Zip

Second parent/guardian  
and/or emergency contact: \_\_\_\_\_ Phone: Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Yes	No	Health Conditions (check)	Yes	No	Allergies (check)	List specifics
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Insect stings	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Foods	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Medications	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	Other	
<input type="checkbox"/>	<input type="checkbox"/>	Cognitive/Developmental	<input type="checkbox"/>	<input type="checkbox"/>	Do any allergies require an EPIPEN injection?	
<input type="checkbox"/>	<input type="checkbox"/>	Any dizziness, light-headedness or fainting associated with exercise within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Is insulin required and carried by youth?	
<input type="checkbox"/>	<input type="checkbox"/>	Any unexplained, rapid or irregular heart beat within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Is an inhaler required and carried by youth?	
<input type="checkbox"/>	<input type="checkbox"/>	A physician has sometime denied or restricted participation in sports due to a heart problem.	Date of last Tetanus booster: (mm/dd/yy)			

Name of Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Medications camper will be taking during event/camp:**

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 or additional information regarding the medication 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, upset stomach, diarrhea):

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

Medication #3	Reason	Dosage (mg)	Times of day given	Prescribing Physician & Phone Number

Describe side effects (mood/behavior changes, upset stomach, diarrhea):

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

**Programs may have limited 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		
<input type="checkbox"/>	<input type="checkbox"/>	Medication(s) has been brought to event/camp.	
<input type="checkbox"/>	<input type="checkbox"/>	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.	
<input type="checkbox"/>	<input type="checkbox"/>	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.

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**Participant Name (Please Print)**

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**SIGNATURE OF PARENT OR LEGAL GUARDIAN**

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**Date**

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