**CU Boulder Youth Program Health History Form**

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| Participant’s Name: |
| Participant’s Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street Address City State Zip Code |
|  |
| Parent / Guardian with legal custody to be contacted in case of illness or injury: |
| Name: | Relationship to Camper: | Preferred Phones:(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Email: |
| Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If different from above Street Address City State Zip Code |
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| Second Parent / Guardian or other emergency contact: |
| Name: | Relationship to Camper: | Preferred Phones:(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Email: |
| Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If different from above Street Address City State Zip Code |
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| Additional contact in the event the above cannot be reached: |
| Name: | Relationship to Camper: | Preferred Phones:(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Allergies:** [ ]  No Know Allergies [ ] This participant is allergic to: [ ] Food Medication [ ] The Environment (insect stings, hay fever, etc.) [ ] Other***(Please describe below what the participant is allergic to and the potential reaction.)*** |
| **Diet, Nutrition:** [ ] This participant eats a regular diet. [ ]  This participant eats a regular vegetarian diet.[ ]  This participant is lactose intolerant. [ ] This participant is gluten intolerant. [ ]  Other, ***please explain in space below.*** |
| **Parent/Guardian Authorization for Health Care:****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 noted by me and/or an examining physician. I give permission to the physician selected by the youth program to order x-rays, routine tests, and treatment related to the health of my participant for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this participant. I understand the information on this form will be shared on a “need to know” basis with program staff. I give permission to photocopy this form. In addition, the program has permission to obtain a copy of my participant’s health record from providers who treat my participant and these providers may talk with the program’s staff about my participant’s health status.**Signature of Custodial RelationshipParent/Guardian Date: to Camper:  |

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| **Medication, Accommodations, and Restrictions** |
| The University of Colorado Boulder policy does not allow staff to engage in the administration of participants’ medication, including over the counter medications. In the case of an emergency, staff will engage in first aid and CPR, and contact emergency medical services (EMS). Staff will then address the situation in accordance with the directives of EMS.**With the exception of EPI-Pens**, participants who need to take medication while attending the programing must either self-administer the medication or work with the CU Boulder Center for Disability and Access to obtain an accommodation. If your participant is unable to self-administer medication, please contact the CU Boulder Center for Disability and Access.The Center for Disability and Access can be contacted at (ADACoordinator@colorado.edu) or by phone (303-492-9725) |
| **Medication:** [ ]  This participant will not take any daily medications while attending the programing. [ ]  This participant will take the following medication(s) while attending programing.“Medication” includes vitamins, natural remedies, and over the counter medications.

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| Name of Medication | Date Started | Reason for Taking it | When it is taken | Amount or Dose | How it is given | Self-Administer and Carry? |
|  |  |  | [ ]  Breakfast[ ]  Lunch[ ]  Dinner[ ]  Bedtime[ ]  Other time:\_\_\_\_\_\_\_\_\_\_\_ |  |  | [ ]  Yes[ ]  No |
|  |  |  | [ ]  Breakfast[ ]  Lunch[ ]  Dinner[ ]  Bedtime[ ]  Other time:\_\_\_\_\_\_\_\_\_\_\_ |  |  | [ ]  Yes[ ]  No |
|  |  |  | [ ]  Breakfast[ ]  Lunch[ ]  Dinner[ ]  Bedtime[ ]  Other time:\_\_\_\_\_\_\_\_\_\_\_ |  |  | [ ]  Yes[ ]  No |
|  |  |  | [ ]  Breakfast[ ]  Lunch[ ]  Dinner[ ]  Bedtime[ ]  Other time:\_\_\_\_\_\_\_\_\_\_\_ |  |  | [ ]  Yes[ ]  No |

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| **Self-Administration and Medication Guidelines:** Participants must only carry sufficient medication for a single day or for the duration of the event. These daily doses should minimally be labeled with;

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| * participant’s name
* name of the drug
* dosage
 | * time for administering
* name of the medical provider
* current date
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It is also recommended that they carry their written authorization from the provider to self-administer. | **Restrictions:** [ ]  I have reviewed the program and activities and give authorization for my participant can participate without restrictions.[ ]  I have reviewed the program and activities and give authorization for my participant can participate with the following restrictions or adaptions.***(Please describe below)*** |
| **Non-Medication Related Accommodations:** University of Colorado Boulder is committed to making our events and programming accessible to everyone. Some accommodations will be able to be met by Program Staff. Others will need to go through the CU Boulder Center for Disability and Access. Please outline your participant(s) request:  |

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| **Immunization History:** Provide the month and year for each immunization. Starred \* immunizations must include date.

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| Immunization | Dose 1Month/Year | Dose 2Month/Year | Dose 3 Month/Year | Dose 4 Month/Year | Dose 5 Month/Year | Most Recent DoseMonth/Year |
| Diptheria, tetanus, pertussis (DTaP) or (TdaP) |  |  |  |  |  |  |
| Tetanus booster\* (dT) or (TdaP) |  |  |  |  |  |  |
| Mumps, measles, rubella (MMR) |  |  |  |  |  |  |
| Polio (IPV) |  |  |  |  |  |  |
| Haemophilus influenzae type B (HIB) |  |  |  |  |  |  |
| Pneumococcal (PCV) |  |  |  |  |  |  |
| Hepatitis B |  |  |  |  |  |  |
| Hepatitis A |  |  |  |  |  |  |
| Varicella (chicken pox) | [ ]  Had Chicken PoxDate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |
| Meningococcal meningitis (MCV4) |  |  |  |  |  |  |
| Tuberculosis (TB) test | Date: |  [ ]  Negative [ ]  Positive |  |  |  |

If your participant has not been fully immunized, please sign the following statement: I understand and accept the risks to my participant from not being fully immunized.Signature of Custodial Parent / Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **General Health History:** *Check “Yes” or “No” for each statement. Explain “Yes” answers below.*Has/does the participant: |
| 1. Ever been hospitalized? ………………………..................[ ]  Yes [ ]  No | 11. Had fainting or dizziness?..........................................................[ ]  Yes [ ]  No |
| 2. Ever had surgery? .....................……….......................[ ]  Yes [ ]  No | 12. Passed out/had chest pain during exercise?..............………....[ ]  Yes [ ]  No |
| 3. Have recurrent/chronic illnesses? .......….….............[ ]  Yes [ ]  No | 13. Had mononucleosis (“mono”) during the past 12 months?...[ ]  Yes [ ]  No |
| 4. Had a recent infectious disease? .....……..................[ ]  Yes [ ]  No | 14. If female, have problems with periods/menstruation?...........[ ]  Yes [ ]  No |
| 5. Had a recent injury? ...........................……….............[ ]  Yes [ ]  No  | 15. Have problems with falling asleep/sleepwalking?...................[ ]  Yes [ ]  No |
| 6. Had asthma/wheezing/shortness of breath?.........[ ]  Yes [ ]  No  | 16. Ever had back/joint problems?.................................................[ ]  Yes [ ]  No |
| 7. Have diabetes? ..................................…………...........[ ]  Yes [ ]  No | 17. Have a history of bedwetting?.................................................[ ]  Yes [ ]  No |
| 8. Had seizures? ............................................................[ ]  Yes [ ]  No | 18. Have problems with diarrhea/constipation?...........................[ ]  Yes [ ]  No |
| 9. Had headaches? …………………………………..................[ ]  Yes [ ]  No | 19. Have any skin problems?..........................................................[ ]  Yes [ ]  No |
| 10. Wear glasses, contacts, or protective eyewear?..[ ]  Yes [ ]  No | 20. 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. |
| **Mental, Emotional, and Social Health: *Check “Yes” or “No” for each statement.***Has the participant:1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?...................................[ ]  Yes [ ]  No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.................................................................................[ ]  Yes [ ]  No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?........................................................[ ]  Yes [ ]  No
4. Had a significant life event that continues to affect the camper’s life?..................................................................................................[ ]  Yes [ ]  No

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)***Please explain “Yes” answers in the space below,*** noting the number of the questions. The camp may contact you for additional information. |
| **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 the participant’s ability to fully participate in the camp program. ***Attach additional information if needed***. |