

Minors Health History

Participant's Name: _____			
Participants Address: _____			
Street Address	APT#	City	State Zip
Parent(s)/Guardian(s) (Legal Guardian)			
Name:	Relationship to Minor:	Preferred Phone Number: _____ _____	Preferred Email:
Address: _____			
(*If different from above) Street Address APT# City State Zip			
Emergency Contacts List 3			
Name:	Relationship to Minor:	Preferred Phone Number: _____ _____	Preferred Email:
Allergies:		<i>What is the participant allergic to and what is the reaction?</i>	
<input type="checkbox"/> No Know Allergies <input type="checkbox"/> Food <input type="checkbox"/> Medication <input type="checkbox"/> The Environment (insect stings, hay fever, etc.) <input type="checkbox"/> Other		 	
Diet, Nutrition:			
<input type="checkbox"/> Vegetarian (VG) <input type="checkbox"/> Vegan (V) <input type="checkbox"/> Hala (H) <input type="checkbox"/> Koher (K) <input type="checkbox"/> Gluten-Free (GF) <input type="checkbox"/> Dairy <input type="checkbox"/> Nut-Free <input type="checkbox"/> Shellfish-free <input type="checkbox"/> Other <input type="checkbox"/> None		<i>If other, please explain in the space below.</i> 	
Medication, Accommodations, Restrictions			
<p>The University of Anschutz Medical Campus policy does not allow staff to administer participants' medication, including over-the-counter medications. In an emergency, program personnel will engage in first aid and CPR and contact emergency medical services (EMS). Program personnel will then address the situation in accordance with EMS directives.</p> <p>With the exception of EPI-Pens, participants who need to take medication while attending the programming must self-administer the medication. <i>Please list all prescription and non-prescription medications below:</i></p> <p style="text-align: center;">- .</p>			

- .
- .
- .

Medication:

- This participant will not take any daily medications while attending the programming.
 This participant will take the following medication(s) while attending programming.

**Medication* includes vitamins, natural remedies, and over-the-counter medications.*

Name of Medication	Date Started	Purpose for Taking	Time Take	Does Amount	Administered	Self Administered and Carry
						Yes No
						Yes No
						Yes No

Self-Administration and Medication Guidelines:

Participants must only carry sufficient medication for a single day or the event's duration. These daily doses should minimally be labeled with:

- Participant's Name
- Name of Medication
- Dosage
- Administration Time
- Medical Providers Name
- Current Date

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 authorized my participant to participate without restrictions.
- I have reviewed the program and activities and give authorization for my participant can participate with the following restrictions or adaptations.
(Please describe below)

Additional Information:

Please provide additional information about the participant's health that you think is important or that may affect the participant's ability to participate in the camp program fully. **Attach additional information if needed.**

Parent/Guardian Authorization for Health Care:

Parent/Guardian Signature: _____ Date: _____