UW-Extension Trempealeau County

PART ONE: 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 at the University of Wisconsin-Trempealeau County 4-H sponsored trip, it is policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device can be self-administered or be administered by the Club Supervisor.

All medications must be in a medicine bottle and labeled with the club member's name, doctor's name and phone number, medication name, and dosage. You must also complete the form

Day(s)to be taken

No medication has been brought to camp.

I want the medication or medical devices self-administered. (Age 14 and above only.)

I want the medication or medical device administered by the Club Supervisor. However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

Prescribing Doctor Doctor's Phone #

When to be administered

Special Instructions

- If your son, daughter, or ward will be under the age of 18 years while on our trip, it is our policy to secure your consent for medical treatment.
- By signing below you are giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- By signing below you are stating that you are aware of and accept the risk inherent in the program activity.
- By signing below you agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin-Trempealeau County, their officers, employees and agents, from any and all liability, loss, damages, or expenses which are sustained, or required arising out of the actions of your dependent in the course of the event.

Participant Name (Please Print)		
Signature of Parent or Guardian	 Date	

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PART TWO: HEALTH HISTORY QUESTIONNAIRE		
Full Participant Name:	Name of Trip/Event: Trip Dates:	
Full Home Address:	Home Telephone Number:	
Date of Birth:/ Sex: M F	Height: Weight:	
Parent/Guardian Name:	Relationship:	
Address (if different than above)	Home Telephone Number: (if different than above)	
Does participant have allergic reactions to:	Parent/Guardian Work Telephone:	
☐ Yes ☐ NoPenicillin☐ Yes ☐ NoOther Antibiotics	Does participant take medication on a regular basis? ☐ Yes ☐ No If Yes, Identify	
☐ Yes ☐ NoOther Medicine (type)	(consent for medication administration must be signed on reverse.)	
☐ Yes ☐ NoInsect Bites/Stings		
Alternate contact in the event that the Parent/Guardian cannot be contacted during an injury or illness. (Name, Relationship, Address, and Telephone Number) Physician: Telephone: Policy No.:		
Has participant had or presently experiencing: Yes No Allergies Yes No Asthma Yes No Bleeding Disorder Yes No Cancer Yes No Colitis Yes No Diabetes Yes No Epilepsy/Seizures/Blackouts Yes No Heart Disease Yes No Hernia Yes No High Blood Pressure Yes No Joint Injury/Surgery Yes No Kidney Disease Yes No Menstrual Difficulties	Immunization Record * MMR (measles, mumps, rubella) Dose 1-Immunization at age 1 □ Yes □ No Dose 2 □ Yes □ No □ * Tetanus-Diphtheria □ Yes □ No □ * Year of last tetanus boost (must be within last 10 years) Has participant ever had major surgery or been hospitalized? □ Yes □ No □ Yes □ No Menstrual Difficulties □ Yes □ No Mental/Emotional Problems □ Yes □ No Rheumatic Fever □ Yes □ No Tuberculosis □ Yes □ No Ulcer Other:	
Please explain any significant operations, accidents or illnesses, and last medical attention and reason:		
Does the participant have any physical condition(s) requiring special considerations? Explain.		
A physical examination within 24 months of the trip/event is recommended. Date of participant's last physical examination:		