PLEASE PRINT

YOUTH DYNAMICS

Health Information Form

Form Revised 1/2025

Please read and complete the entire form, front and back, carefully. You must complete and sign **both** this form and the Participant Agreement Form in order to participate. Incomplete or missing information and/or signature will prevent participation.

Participant

Name of Participant | Date of Birth (Month/Day/Year) | Age | Sex

Home Address | City | State | Zip

Cell Phone of Parent/Guardian | Email of Parent/Guardian | Height | Weight

Emergency Contact

Parent/Guardian

Emergency Contact Name / Relationship | Emergency Cell/Phone

Emergency Contact Address | City | State | Zip

Health Insurance

Participant's Family Physician Name | Physician's Phone

Health Insurance Company | Health Insurance ID Number | Health Insurance Phone

Health History

Directions: Check YES or NO if the participant "currently has" or "has a history of" the following conditions. Please explain all "yes" answers, and contact us with any concerns regarding the impact of activities with relation to the below medical history.

General Medical History

Yes	No	
☐	☐	Heart problems, Low/High blood pressure? Explain:
☐	☐	Diabetes? Explain:
☐	☐	Respiratory problems? Asthma? Explain: (please note if you carry an inhaler, what triggers an attack? last episode? ever hospitalized?)
☐	☐	Allergies? (Bees, Medications, Foods, etc.) Explain: (please specify what you are allergic to, note last episodes)
☐	☐	Gastrointestinal conditions, dietary restrictions? Explain:
☐	☐	Neurological problems? Epilepsy? Seizures? Explain:
☐	☐	Migraines, dizziness, fainting spells? Explain: (please describe the frequency, date of last episode, severity)
☐	☐	Current communicable disease? Explain:
☐	☐	Behavioral disorders? Explain:
☐	☐	Other Pertinent conditions? Explain:

Must complete other side

Yes No Muscle/Skeletal Injuries/Fractures

☐ ☐ Recent sprains, fractures, or dislocations? Explain: _____

☐ ☐ Shoulder, arm or back injuries? Explain: _____

☐ ☐ Knee, hip or ankle injuries and/or surgery? Explain: _____

☐ ☐ Head injury or surgery? When did this occur occur? Explain: _____

☐ ☐ Is there limited range of motion? Explain: _____

Yes No Fitness Information

☐ ☐ Does the applicant exercise regularly?

What activity? _____

Swimming Ability:

Non-Swimmer ☐ Swimmer ☐

We are unable to take women rafting during pregnancy.

Yes No Female Participants ONLY:

☐ ☐ Is the applicant currently pregnant?

Please list any pertinent information regarding menstrual cycles:

_____

_____

Immunizations should be kept current, please list any pertinent information we should be aware of regarding: Tetanus, Mumps, Measles, Rubella, Hepatitis A & B immunizations.

_____

_____

_____

Yes No Note pertinent Cold, Heat, Altitude Illness Information

☐ ☐ Frostbite, hypothermia related illness?
Explain: _____

☐ ☐ Heat stroke or other heat related illness?
Explain: _____

☐ ☐ Altitude related illness?
Explain: _____

Prescription Medications:

In the space below please list out all current prescription medications being used, include name of the medication, dosage, side effects, prescribed by, for what conditions? (**This same information must be included with the medications**)

_____

_____

_____

_____

Over-the-Counter Medications:

Some "over the counter" (OTC) medications are available for underage participants, but only with parent/guardian consent.
If you would like your student to have access to **ALL** OTC medications, please initial here _____ for "YES".
But, if you would prefer to only have certain medication made available, check ONLY those boxes below.

_____ 100% Aloe vera gel
_____ Tecnu cream for poison oak
_____ Hydrocortisone anti-itch creme
_____ Eye wash
_____ Aspirin
_____ Anti-diarrhea medicine
_____ Nasal decongestant
_____ Acetaminophen/Tylenol (extra strength)
_____ Ibuprofen/Advil
_____ Naproxen sodium/Aleve
_____ Antihistamine/Allergy medication
_____ Blistex/Lip ointment
_____ Pepto-Bismol/Indigestion medicine
_____ Metamucil/Fiber laxative

Consent for Treatment

In the event of a medical emergency, I hereby give permission to YD staff to administer or obtain medical treatment, which may include hospitalization, surgery, ordering of injection, administering of anesthesia, or taking of medication(s) for the minor participant or me. I authorize YD staff and the third party medical care provider to exchange medical information pertinent to the care sought. I agree to pay all the costs of rescue and medical services incurred on my or the child's behalf.

_____ _____

Participant's Printed Name Participant's Age

Signature (18 years & older): _____ _____

Participant's Signature OR Parent/Guardian's Signature Date Signed