

# HEALTH HISTORY QUESTIONNAIRE

**PARTICIPANT INFORMATION**

NAME: \_\_\_\_\_  
LAST FIRST MI

HOME ADDRESS: \_\_\_\_\_  
STREET ADDRESS

\_\_\_\_\_ CITY ST ZIP

HOME PHONE: \_\_\_\_\_

CELL/OTHER PHONE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_  MALE  FEMALE

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ LBS.

**CONTACT INFORMATION**

PARENT/GUARDIAN NAME: \_\_\_\_\_  
LAST FIRST RELATIONSHIP

ADDRESS (CHECK IF SAME AS STUDENT ): \_\_\_\_\_  
STREET ADDRESS

\_\_\_\_\_ CITY ST ZIP

HOME PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

**IN CASE OF EMERGENCY, IF I AM UNABLE TO BE CONTACTED, PLEASE CONTACT:**

\_\_\_\_\_ LAST NAME FIRST NAME RELATIONSHIP

\_\_\_\_\_ 1ST PHONE 2ND PHONE

**MEDICAL INFORMATION**

NAME OF PHYSICIAN: \_\_\_\_\_ MEDICAL FACILITY: \_\_\_\_\_ PHONE: \_\_\_\_\_

**IMMUNIZATION RECORD:**

MMR (measles, mumps, rubella): DOSE 1: IMMUNIZATION AT 12 MONTHS \_\_\_\_\_ DOSE 2: \_\_\_\_\_

Tetanus/Diphtheria: DATE OF INITIAL SERIES \_\_\_\_\_ DATE OF LAST BOOSTER \_\_\_\_\_

Has the participant ever had a major surgery or been hospitalized?  YES  NO Please explain any significant operations, accidents, illnesses, etc:  
 \_\_\_\_\_

Does the participant have any physical condition(s) requiring special consideration?  YES  NO IF YES, IDENTIFY: \_\_\_\_\_

Does the participant regularly take medicine or utilize emergency medications?  YES  NO IF YES, IDENTIFY: \_\_\_\_\_

**CHECK ANY ALLERGIES THE PARTICIPANT MAY HAVE:**

PARTICIPANT HAS NO KNOWN ALLERGIES

PENICILLIN \_\_\_\_\_

OTHER ANTIBIOTICS \_\_\_\_\_

OTHER MEDICINES \_\_\_\_\_

INSECT BITES/STINGS \_\_\_\_\_

FOOD \_\_\_\_\_

OTHER \_\_\_\_\_

**SPECIAL MEDICAL CONDITIONS**

ASTHMA  HIGH BLOOD PRESSURE  KIDNEY DISEASE  EPILEPSY/SEIZURE DISORDER  CEREBRAL PALSY  RHEUMATIC FEVER  HEART DISEASE  DIABETES  ULCER

EMOTIONAL/BEHAVIORAL DISORDER  BLEEDING DISORDER  CANCER  NECK/BACK PAIN  GASTROINTESTINAL DISORDER  COLITIS  TUBERCULOSIS  HERNIA  OTHER \_\_\_\_\_

# CONSENT FOR MEDICAL TREATMENT

\_\_\_\_\_  
**PARTICIPANT NAME - PLEASE PRINT**

- If your son, daughter, or ward will be under the age of 18 years while participating in an activity with Upward Bound, Educational Talent Search or a camp, it is our policy to secure your consent in the event that medical treatment is warranted.
- 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 program activities.
- By signing below, you agree to hold harmless and indemnify the State of Wisconsin, the Board of Regents of the University of Wisconsin System, and the University of Wisconsin –Whitewater, 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 your dependent in the course of the event/camp.

\_\_\_\_\_  
**Name of Parent or Guardian (Please Print)**

\_\_\_\_\_  
**Signature of Parent or Guardian**

\_\_\_\_\_  
**Date**

*(CONTINUING PARTICIPANTS ONLY)*

## RECERTIFICATION

*(CONTINUING PARTICIPANTS ONLY)*

By signing below, you are verifying that the participant, contact, and medical information on the other side of this form is accurate and current; and, that your consent for medical treatment is still valid. If any information has changed, we ask that you complete a new Health History Questionnaire. New forms can be obtained by contacting our office at 1-800-991-5570 or 1-800-991-5562.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

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Date