UNIVERSITY OF WISCONSIN WHITEWATER
PreCollege Programs

Upward Bound Participant: HEALTH INFORMATION

PARENT INFORMATION

PARENT/GUARDIAN NAME*:	**Program:** UWW Upward Bound
RELATIONSHIP*:	**HOME PHONE*:**
CELL PHONE*:	**EMAIL*:**
ADDRESS*:	**CITY*:**
STATE, ZIP CODE*:	**COUNTRY*:**

UPWARD BOUND PARTICIPANT INFORMATION

UB PARTICIPANT NAME*:	**DATE OF BIRTH** (mm/dd/yyyy) ***:**
GENDER*:	**HEIGHT** (ft.)**, WEIGHT** (lb.) **:**
ADDRESS*: (if same as parent's, write "same")	**CITY*:**
STATE, ZIP CODE*:	**COUNTY*:**

OTHER EMERGENCY CONTACT

NAME*:	**RELATIONSHIP*:**	**PHONE*:**

INSURANCE & DOCTOR INFORMATION

PRIMARY CARE PROVIDER*:	**PHONE*:**
DENTIST *:	**PHONE*:**
ORTHODONTIST*:	**PHONE*:**
INSURANCE COMPANY*:	**POLICY NUMBER*:**
GROUP/ID NUMBER*:	**NAME OF POLICY HOLDER*:**

ALLERGY INFORMATION (skip if no allergies)

ALLERGY TYPE: ☐ **DRUG** ☐ **ENVIRONMENTAL** ☐ **FOOD** ☐ **LIFE THREATENING?** ☐	
ALLERGIC TO:	**REACTION:**

ALLERGY TYPE: ☐ **DRUG** ☐ **ENVIRONMENTAL** ☐ **FOOD** ☐ **LIFE THREATENING?**	
ALLERGIC TO:	**REACTION:**

If your child has more than 2 allergies, please type out the remaining allergies on a separate piece of paper specifying the above information for each.

*** Information is Required**

RESTRICTIONS (put an "X" in all that apply)

DIET*:	☐	**NONE**	☐	**VEGETARIAN**	☐	**VEGAN**	☐	**KOSHER**	☐	**OTHER:** Please specify,
ACVITITY*:	☐	**NO**	☐	**YES**	Please describe,					

MEDICATION INFORMATION (skip if no medications)

By Wisconsin state law, medication must be administered by the camp staff to all campers under age 18.

MEDICATION TYPE:	☐	**PRESCRIPTION**	☐	**OVER THE COUNTER**	**STRENGTH:**		**DOSE:**	
MEDICATION NAME:					**TIME(S) TO GIVE:** (breakfast, lunch, dinner, as needed)			
DATES TO GIVE MEDICATION:					**DETAILS:**			

MEDICATION TYPE:		**PRESCRIPTION**		**OVER THE COUNTER**	**STRENGTH:**		**DOSE:**	
MEDICATION NAME:					**TIME(S) TO GIVE:** (breakfast, lunch, dinner, as needed)			
DATES TO GIVE MEDICATION:					**DETAILS:**			

If your child has more than 2 medications, please write out the remaining medications on a separate piece of paper specifying the above information for each.

MEDICAL HISTORY (put an "X" in all that apply)

☐	**Hospitalized**	☐	**Fainting/dizziness**
☐	**Surgery**	☐	**Passed out/had chest pain during exercise**
☐	**Recurrent/chronic illnesses**	☐	**"Mono" in the last 12 months**
☐	**Recent infectious disease**	☐	**Problems with menstruation**
☐	**Recent injury**	☐	**Problems with falling asleep/waking**
☐	**Asthma/wheezing/shortness of breath**	☐	**Back/joint problems**
☐	**Diabetes**	☐	**History of bedwetting**
☐	**Seizures**	☐	**Problems with diarrhea/constipation**
☐	**Headaches**	☐	**Skin problems**
☐	**Glasses/contacts/protective eyewear**	☐	**Traveled outside country in past 9 months**

Details:	

Authorization/Consent

It is our policy to secure your consent in the event the medical treatment is warranted during Upward Bound activities. By signing you are giving your consent in advance for the medical treatment at an appropriate medical facility in care of illness or injury. By signing you are stating that you are aware of and accept the risk inherent in the program activity. By signing you agree to hold harmless and indemnify the state of Wisconsin, the board of Regent 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 of expenses which are sustained, incurred or required arising out of the action of your dependent in the program.

By providing your signature you authorize us to update your child's health information.

	I agree*	**Parent/Guardian First Name*:**	**Parent/Guardian Last Name*:**	**Relationship*:**
Parent/Guardian Signature:				**Today's Date*:**
	I agree*	**Student First Name*:**	**Student Last Name*:**	
Student Signature:				**Today's Date*:**

Please attach your child's immunization record to this form.

*** Information is Required**