PLEASE PRINT

YOUTH DYNAMICS

Health Information Form

FOR OFFICE USE ONLY
Group: _____
Date: _____
Form Revised 1/2024

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

Height | Weight | Eye Color | Hair Color

Home Address | Parent/Guardian City | State | Zip

Cell Phone | Parent/Guardian Phone | Email

Emergency Contact
Parent/Guardian

Emergency Contact Name / Relationship | Daytime Phone | Evening Phone | Cell Phone

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: Circle YES or NO if the participant "currently has" or "has a history of" the following. Please provide further detail for all "yes" answers in the blank space provided.

Yes No General Medical History

- Heart problems?
  Explain: _____
- Low or high blood pressure?
  Explain: _____
- Respiratory problems? Asthma? *(please note if you carry inhaler)* What triggers an attack? Last episode? Ever hospitalized?
  Explain: _____
- Allergies? *(Bees, Medications, Foods, etc.)* Please specify what you are allergic to? Last episode?
  Explain: _____
- Dietary restrictions?
  Explain: _____
- Gastrointestinal disturbances?
  Explain: _____
- Diabetes?
  Explain: _____
- Blood disorders, bleeding, or DVT? *(deep vein thrombosis)*
  Explain: _____
- Hepatitis or other liver disease?
  Explain: _____
- Neurological problems? Epilepsy? Seizures?
  Explain: _____
- Migraines? Describe frequency. Date of last episode, severity:
  Explain: _____
- Dizziness, fainting spells?
  Explain: _____
- Thyroid trouble?
  Explain: _____
- Current communicable disease?
  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 the injury/surgery occur? Explain: _____

_____

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

What's been your most rigorous activity since the injury? Results? Explain: _____

Yes No Fitness:

☐ ☐ Does the applicant exercise regularly ?
Activity_____Frequency_____
Intensity Level: ☐ *Easy* ☐ *Moderate* ☐ *Competitive*

☐ ☐ Does the applicant smoke?
If so, how much?_____

☐ ☐ Is the applicant overweight? Underweight? *(circle one)*
If so, how much?_____

Swimming Ability: ☐ *Non-swimmer* ☐ *Recreational* ☐ *Competitive*

Yes No Female Participants ONLY:

☐ ☐ **We are unable to take pregnant women rafting regardless of the state of the pregnancy.**

☐ ☐ Is the applicant currently pregnant?
Treatment or medication for menstrual cramps

Other pertinent Health History information:

_____

_____

Immunizations:

Date of last time immunized	Date
Tetanus (Every 10 years)	
Mumps, Measles, Rubella	
Hepatitis A	
Hepatitis B	

Yes No Cold, Heat, Altitude

☐ ☐ Frostbite, hypothermia?
Explain: _____

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

☐ ☐ Altitude related sickness?
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:

Youth Dynamics carries various "over the counter" (OTC) medications, only made available to underage participants with parent/guardian consent.

If you would like your student to have access to **ALL** OTC medications, please initial _____ for "YES", otherwise please select from the list 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***