



Name of Group: _____
Date of SHCC Event: _____

Participant Health Summary

This information is confidential but may be shared with appropriate personnel when necessary.

Personal Information:

Participant's Name: _____ Gender: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Height: _____ ft. _____ in. Weight: _____ lbs.

Emergency Contact: Please indicate language spoken at home: _____

Please list two people who may be contacted in the case of an emergency.

Name: _____ Relationship: _____ Daytime phone: _____
Name: _____ Relationship: _____ Daytime phone: _____

Health Information:

YES NO If Yes, please share detail below

Allergies - Food, seasonal, insect bite/sting, medication	<input type="checkbox"/>	<input type="checkbox"/>	Is any emergency medication used? If so, list below along with any action plan..
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Is an inhaler needed? If so, list below and provide any action plan?
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	List any medications used below and provide an action plan.
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Is emergency medication used? If so, list below and provide action plan.
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	
History of head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing/vision/speech concerns	<input type="checkbox"/>	<input type="checkbox"/>	
Serious illness/accidents	<input type="checkbox"/>	<input type="checkbox"/>	
Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	Anything that would impact joints, balance, movement, level of exertion?
Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	

I give permission for my child to take the appropriate dose of the following medications as needed:
_____ Ibuprofen (Advil/Motrin) _____ Acetaminophen (Tylenol)

Is there anything else you think staff should be aware of that may affect participation during this experience?

Participant Signature: _____ Date: _____

Parent/Guardian Signature (If participant is under 18) _____ Date: _____