



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			Is any emergency medication used? If so, list below along with any action plan..
Asthma			Is an inhaler needed? If so, list below and provide any action plan?
Diabetes			List any medications used below and provide an action plan.
Seizures			Is emergency medication used? If so, list below and provide action plan.
Heart condition			
Headaches/Migraines			
History of head injury			
Hearing/vision/speech concerns			
Serious illness/accidents			
Surgeries			Anything that would impact joints, balance, movement, level of exertion?
Pregnant?			

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: \_\_\_\_\_