UNIVERSITY OF MARYLAND EXTENSION
Solutions in your community

UNIVERSITY OF MARYLAND EXTENSION
ADULT AND YOUTH HEALTH FORM MEP 323

☐ Youth ☐ Adult

Participant's Name _____ Sex_____
Last First Middle Initial Nickname

Age as of Jan. 1of current year _____ Birth date _____

Complete Home Address_____

Telephone: day (_____)_____ Telephone: evening (_____)_____

Name of Custodial Parent/Guardian_____

Home Telephone (_____) _____ Work Telephone (_____) _____

Name of Non-Custodial Parent/Guardian_____

Home Telephone (_____) _____ Work Telephone (_____) _____

If Parent/Guardian is not available in an emergency, contact:_____

Telephone (_____) _____ Relationship to Individual_____

Family Primary Care Physician_____ Telephone (_____) _____

Family Dentist _____ Telephone (_____) _____

Family Health Insurance Carrier_____

Policy Number _____ Name of Insured _____

☐ No Insurance Coverage

☐ Insurer requires authorization from primary care physician prior to treatment.

Health History

Check all that apply; give approximate date of onset

☐ Frequent Ear Infections
☐ Seizure Disorder/Convulsions
☐ Mononucleosis
☐ Asthma
☐ German Measles (Rubella)
☐ Menstrual Cycle Started
☐ Bed Wetting
☐ Heart Defect/Disorder
☐ Diabetes
☐ Sleep Walking
☐ Chicken Pox
☐ Mumps
☐ Urinary Tract Infection
☐ Recent Surgery: Please explain
☐ High Blood Pressure
☐ Bleeding Clotting Disorders
☐ ADD/AD HD
☐ Measles
☐ Hepatitis
☐ Head Injury

Please list any additional important health information or dietary restrictions.

Allergies Check all that apply.

☐ Hay Fever
☐ Poison Ivy, Oak, etc.
☐ Insect Bites
☐ Insect Stings*
☐ Penicillin
☐ Sulfa
☐ Iodine
☐ Other allergies: Please List Below
☐ Foods allergies: Please List Below

☐ This individual requires immediate medical attention for treatment of allergies — please specify .

*Please note if epinephrine is with adult/child

Name
Housing
Program
Year

Immunization History

Please record month and year of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria		
Pertussis		
Tetanus		
Chickenpox		
Oral Polio		
Injectable Polio		
Measles		
Mumps		
Rubella		
TB Test		
Haemophiles influenza B	- Most Recent:	
Hepatitis B		
Other		

Medications

Please list ALL medications the individual routinely takes. Bring at least enough medication to last for the program's duration. Keep medication in the original container, which identifies the name of the medication, its dosage, and frequency of administration; the prescription number; and the physician's name and phone number.

Prescription

Medication	Dosage	Specific Times Taken	Reason For Taking

Non-Prescription

Medication	Dosage	Specific Times Taken	Reason For Taking

☐ Individual requires no regular medication.

I give permission to the selected UME staff or volunteer to administer the medications listed above, along with any of the following additional medications that I have checkmarked, if the staff or volunteer deems it necessary.

☐ Acetaminophen ☐ Aspirin ☐ Ibuprofen ☐ Pepto Bismol
☐ Calamine lotion ☐ Immodium AD ☐ Cough drops ☐ Sunscreen

Dosages will be administered according to directions on the container unless a physician directs otherwise. Additional information, for medical staff only, may be attached in sealed envelope.

Signature of Participant or Parent/Guardian if participant is under 18 years old | **Print Name of Parent/Guardian** | **Date**

Participation

This participant is allowed to participate fully in this (Program name) _____, which may include swimming, canoeing, hiking, sports, and other strenuous events/activities.

☐ Yes ☐ No Specify restriction _____

Additional information for health care staff: _____

_____

Signature of Participant or Parent/Guardian if participant is under 18 years old	Print Name of Parent/Guardian	Date

AUTHORIZATION FOR PARTICIPTION AND RELEASE: I hereby give permission for medical personnel selected by University of Maryland Extension (UME) to provide routine health care; to order x-rays, and routine tests; to administer medications, injections, anesthesia, surgery, and other treatment; to release records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission for medical personnel selected by UME to secure and administer treatment including hospitalization for the participant named above. I further understand that I will be responsible for medical/hospital bills. By signing this form, I give permission for the participant named above to participate in all program activities except as specified herein. This completed form may be copied for trips out of camp and/or away from the program site. By signing this form, I release and forever discharge, agree not to sue, and to indemnify and hold harmless the State of Maryland, University of Maryland, and University of Maryland Extension and/or their officers, agents, employees, faculty, staff, and volunteers from and against any and all liabilities, costs, expenses, causes of action, claims, and/or demands in any way relating to the foregoing program activities and/or the health, illness, injury, and/or treatment of the participant named above.

I AM 18 YEARS OLD OR OLDER AND I HAVE READ AND FULLY UNDERSTAND THIS AUTHORIZATION FOR PARTICIPTION AND TREATMENT AND RELEASE.

Signature of Participant or Parent/Guardian if participant is under 18 years old	Print Name of Participant or Parent/Guardian if participant is under 18 years old	Date
	(Or)	
Signature of Parent/Guardian of 18 year old (optional)	Print Name of Parent/Guardian of 18 year old (optional)	Date

THIS SECTION FOR OVERNIGHT RESIDENTIAL PROGRAM PARTICIPANTS ONLY.

HEALTH EXAM To be completed by doctor

Participation

This individual is allowed to participate fully in this program, which may include swimming, canoeing, hiking, sports, and other strenuous events:

_____Yes _____No Specify restriction _____

Additional information for health care staff: _____

_____

I have examined this individual within the past 2 years. Date Examined _____/_____/_____

Height _____ Weight _____ Blood Pressure _____

Currently under care of physician for _____

Signature of Physician	**Print Name of Physician**	**Date**
Nurse/Physician's Assistant completing form	**Print Name of Nurse/Physician's Assistant**	**Date**

Personal Identification Form

In an effort to provide a safe and enjoyable educational experience, we ask that you complete this information. This information will be used in case of an emergency to help mobilize assistance and to distribute to those providing assistance.

Recent Photograph
(Within Past Year)

Participant's Name_____

Telephone: (_____) _____

Address

Parent/Guardian Name _____

Emergency Contact: _____

Telephone: (_____) _____

Individual's Physical Description

Age _____ Sex _____ Race _____ Height _____ Weight _____

Hair Color _____ Eye Color _____ Glasses ☐ Yes ☐ No Contacts ☐ Yes ☐ No

Facial Features/Shape _____

Teeth (Normal, gaps, chipped, braces, etc.) _____

Distinguishing Marks/Scars _____

Physical Condition _____

Mental Condition _____

Emotional Condition _____

Hobbies & Interests of Individual _____

Personal/Family situation that could cause concerns:

Other habits/personality information that could be helpful

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