



Maryland Cooperative Extension Adult and Youth Health Form

Youth Adult

Participant's Name _____ Sex _____
Last First Middle Initial Nickname

Age as of Jan. 1 of 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

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

Please list any additional important health information or dietary restrictions.

Allergies Check all that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Insect Stings* | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Poison Ivy, Oak, etc. | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other allergies: Please List Below |
| <input type="checkbox"/> Insect Bites | <input type="checkbox"/> Sulfa | <input type="checkbox"/> 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 MCE 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

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.



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 _____
