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 WWW.TYHP.ORG

Texas Youth Hunting Program Health History

(Print and complete one form for each person attending hunt)

NAME AND DATE OF YOUTH HUNT _____			
PARTICIPANT & EMERGENCY CONTACT INFORMATION		<input type="checkbox"/> Youth <input type="checkbox"/> Accompanying Adult <input type="checkbox"/> Volunteer	
Participant Legal Name:			
_____	_____	_____	_____
<small>First</small>	<small>Middle</small>	<small>Last</small>	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Birthdate: ____/____/____	Age: ____ years
Home Address: _____			
<small>Street Address</small>	<small>City</small>	<small>State</small>	<small>Zip Code</small>
Parent/Guardian with legal custody to be contacted in case of illness or injury:			
Name: _____		Relationship to Minor: _____	
Phone: _____		Email: _____	
Second parent/guardian or another emergency contact:			
Name: _____		Relationship to Minor: _____	
Phone: _____		Email: _____	
ALLERGIES Participant: <input type="checkbox"/> Has no known allergies <input type="checkbox"/> Is allergic to:			
<input type="checkbox"/> Food:	<input type="checkbox"/> Medicine:	<input type="checkbox"/> Environment:	<input type="checkbox"/> Other
<input type="checkbox"/> Lactose intolerant	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Insect stings	
<input type="checkbox"/> Gluten intolerant	<input type="checkbox"/> Other	<input type="checkbox"/> Hay fever	
<input type="checkbox"/> Other		<input type="checkbox"/> Other	
Please list and describe the reaction and severity of all known allergies:			
Allergy: _____	Reaction: _____		
Allergy: _____	Reaction: _____		
Allergy: _____	Reaction: _____		
Allergy: _____	Reaction: _____		
PHYSICIAN INFORMATION <i>You may attach a front/back copy of your insurance card instead.</i>			
Name of Physician: _____		Phone Number: _____	
Are your immunizations current and on record? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last tetanus shot _____			

GENERAL HEALTH HISTORY

Do/have you:

If yes, briefly explain:

- | | | |
|---|--|-------|
| 1. Ever been hospitalized? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 2. Ever had surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 3. Have recurrent/chronic illnesses? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 4. Had a recent infectious disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 5. Had a recent injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 6. Had asthma/wheezing/shortness of breath? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 7. Have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 8. Had seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 9. Had reoccurring headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 11. Had fainting or dizziness? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 12. Passed out/had chest pain during exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 13. Have problems with falling asleep/sleepwalking? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 14. Ever had back/joint problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 15. Have any skin problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 16. Traveled outside of the country in the past 9 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

Please use the space below to **further explain any "yes" answers**, noting the number of the question. For travel outside of the country, please name countries visited/dates of travel:

What have we forgotten to ask?

Please provide any additional information about your health that you feel is relevant or may affect your full participation in event activities:

COVID-19 HISTORY

Have you or anyone in your immediate family been exposed to or been diagnosed with Covid-19?

Yes No Please explain date and type of exposure: _____

I do not currently suffer from any of the following acute symptoms: _____ Initials

<ul style="list-style-type: none">• Cough• Shortness of breath or difficulty breathing• Chills• Repeated shaking with chills• Feeling feverish or a temperature greater than or equal to 100.0 degree Fahrenheit	<ul style="list-style-type: none">• Muscle pain• Headache• Sore Throat• Loss of taste of smell• Diarrhea
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I _____ authorize this form to be retained at the TYHP office. Neither this form nor any information on it will be released to any persons or agency.

_____ (sign) _____ (date)