6644 FM 1102, New Braunfels, Texas 78132
Toll Free: (800) 460-5494 ~Fax (210) 524-9032
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 ☐ Youth ☐ Accompanying Adult ☐ Volunteer

Participant Legal Name:

_____
First Middle Last

Gender: ☐ Male ☐ Female **Birthdate:** _____/_____/_____ **Age:** _____ years

Home Address: _____
Street Address City State Zip Code

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: ☐ **Has no known allergies** ☐ **Is allergic to:**

☐ **Food**:	☐ **Medicine**:	☐ **Environment**:	☐ **Other**
☐ Lactose intolerant	☐ Penicillin	☐ Insect stings	
☐ Gluten intolerant	☐ Other	☐ Hay fever	
☐ Other		☐ Other	

Please list and describe the reaction and severity of all known allergies:

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

PHYSICIAN INFORMATION *You may attach a front/back copy of your insurance card instead.*

Name of Physician: _____ Phone Number: _____

Are your immunizations current and on record? ☐ Yes ☐ No Date of last tetanus shot _____

GENERAL HEALTH HISTORY

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

• 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	• Muscle pain • Headache • Sore Throat • Loss of taste of smell • Diarrhea

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)