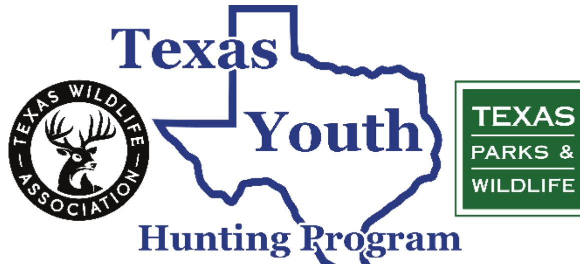


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# Texas Youth Hunting Program Health History

(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

**Primary Emergency Contact to be contacted in case of illness or injury:**

Name: ______________________________Relationship to Participant: ______________________

Phone: ____________________ Email: ______________________________

**Secondary emergency contact:**

Name: ______________________________ Relationship to Participant: ______________________

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. Currently experiencing fever, chills, temperature $\geq 100^o$? | ☐ Yes ☐ No | ______________________________ |
| 5. Had a recent infectious disease? | ☐ Yes ☐ No | ______________________________ |
| 6. Anyone in your party exposed to infectious disease in last 5 days? | ☐ Yes ☐ No | ______________________________ |
| 7. Had a recent injury? | ☐ Yes ☐ No | ______________________________ |
| 8. Had asthma/wheezing/shortness of breath? | ☐ Yes ☐ No | ______________________________ |
| 9. Have diabetes? | ☐ Yes ☐ No | ______________________________ |
| 10. Had seizures? | ☐ Yes ☐ No | ______________________________ |
| 11. Had reoccurring headaches? | ☐ Yes ☐ No | ______________________________ |
| 12. Wear glasses, contacts, or protective eyewear? | ☐ Yes ☐ No | ______________________________ |
| 13. Had fainting or dizziness? | ☐ Yes ☐ No | ______________________________ |
| 14. Passed out/had chest pain during exercise? | ☐ Yes ☐ No | ______________________________ |
| 15. Have problems with falling asleep/sleepwalking? | ☐ Yes ☐ No | ______________________________ |
| 16. Ever had back/joint problems? | ☐ Yes ☐ No | ______________________________ |
| 17. Have any skin problems? | ☐ Yes ☐ No | ______________________________ |
| 18. 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:*

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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)