6644 FM 1102 New Braunfels, TX 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

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)