6644 FM 1102 New Braunfels, TX 78132

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www.texas-wildlife.org

TWA Expeditions Program Health History

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

NAME AND DATE OF EVENT _____

PARTICIPANT & EMERGENCY CONTACT INFORMATION ☐ Youth ☐ Accompanying Adult ☐ Volunteer

Participant Legal Name:

_____

First Middle Last

Gender: ☐ Male ☐ Female ☐ Other **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:
Ever been hospitalized?	☐ Yes ☐ No	_____
Ever had surgery?	☐ Yes ☐ No	_____
Have recurrent/chronic illnesses?	☐ Yes ☐ No	_____
Had a recent infectious disease?	☐ Yes ☐ No	_____
Had a recent injury?	☐ Yes ☐ No	_____
Had asthma/wheezing/shortness of breath?	☐ Yes ☐ No	_____
Have diabetes?	☐ Yes ☐ No	_____
Had seizures?	☐ Yes ☐ No	_____
Had reoccurring headaches?	☐ Yes ☐ No	_____
Wear glasses, contacts, or protective eyewear?	☐ Yes ☐ No	_____
Had fainting or dizziness?	☐ Yes ☐ No	_____
Passed out/had chest pain during exercise?	☐ Yes ☐ No	_____
Have problems with falling asleep/sleepwalking?	☐ Yes ☐ No	_____
Ever had back/joint problems?	☐ Yes ☐ No	_____
Have any skin problems?	☐ Yes ☐ No	_____
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 TWA office. Neither this form nor any information on it will be released to any persons or agency.

_____ (sign)
_____ (date)