GET IT DONE
Turning Passion into Action

2026 NATIONAL IWLA CONVENTION
Youth Program Health & Medical Information Form

Hosted by: Minnesota Division, Izaak Walton League of America
In partnership with: Minnesota Valley Chapter, IWLA

Program Location:
Minnesota Valley Chapter, IWLA
6601 Auto Club Road
Bloomington, MN

PARTICIPANT INFORMATION
Participant Name: _____ Date of Birth: _____ Age: _____
Program (check one):
☐ Youth Convention Participant (Ages 8–14) ☐ Youth Convention Participant (Ages 14–18)
☐ Junior Counselor (Ages 14–17) ☐ Green Crew Summit Participant (Ages 18–21) ☐ ELF (Ages 5–8)

EMERGENCY CONTACT INFORMATION
For Participants Under 18
Parent/Guardian Name: _____
Primary Phone: _____ Secondary Phone: _____

For Participants Ages 18–21
Participant Phone: _____

Emergency Contact (Required for ALL participants)
Name: _____ Relationship: _____ Phone: _____

HEALTH INSURANCE & PHYSICIAN (Optional)
Physician Name: _____ Physician Phone: _____
Health Insurance Provider: _____ Policy Number: _____

ALLERGIES
Does the participant have allergies? ☐ Yes ☐ No
If yes, describe (include severity and treatment): _____
_____
Does the participant carry an EpiPen? ☐ Yes ☐ No

MEDICAL CONDITIONS
Check any that apply and provide details:
☐ Asthma ☐ Diabetes ☐ Seizure disorder
☐ Heart condition ☐ Behavioral ☐ Other: _____
Details / management instructions: _____
_____

ACTIVITY LIMITATIONS
Are there any physical, medical, or behavioral limitations or restrictions? ☐ No restrictions ☐ Yes (please explain):
_____

MEDICATIONS
Is the participant currently taking any medications? ☐ No ☐ Yes If yes, complete below:
Medication Name _____ Dosage _____
When Taken: _____ Instructions _____

MEDICATION ADMINISTRATION AUTHORIZATION
I authorize designated staff or volunteers of the Minnesota Valley Chapter and/or Minnesota Division of the Izaak Walton League of America to:

- Store medications as needed
- Administer medications as directed above

I understand that medications must be provided in original packaging with clear instructions.

Parent/Guardian Signature (if under 18): _____

Participant Signature (18+): _____

OVER-THE-COUNTER (OTC) MEDICATION PERMISSION

I authorize the following to be administered as needed:

- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Advil)
- ☐ Antihistamines (Benadryl or similar)
- ☐ Topical treatments (anti-itch, antibiotic ointment)
- ☐ Additional notes or restrictions: _____

Parent/Guardian Signature (if under 18): _____

Participant Signature (18+): _____

HEALTH STATUS CONFIRMATION

- ☐ I confirm that the participant is in good health and able to participate in program activities, except as noted in this form.
- ☐ I understand that it is my responsibility to update this information if conditions change prior to or during the event.

Parent/Guardian Signature (if under 18): _____

Participant Signature (18+): _____

AUTHORIZATION FOR EMERGENCY CARE

In the event of illness or injury, I authorize program staff to:

- ☐ Provide basic first aid
- ☐ Contact emergency medical services
- ☐ Transport the participant for medical care if necessary
- ☐ I understand that I will be contacted as soon as reasonably possible.

Parent/Guardian Signature (if under 18): _____

Participant Signature (18+): _____