

Adult Event Health Form

Name: _____		Age: _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
E-mail Address: _____				
Phone Numbers: Home (____) _____ - _____	Work (____) _____ - _____	Cell phone (____) _____ - _____		
Home Address: _____				
Street	City	State	Zip	

Emergency Contact: _____		Relationship: _____		
Primary Phone Number (____) _____ - _____		Secondary Phone Number (____) _____ - _____		
Address: _____				
Street	City	State	Zip	

Health Conditions (check)	Yes	No	Allergies (check)	Yes	No	List specifics
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Insect stings	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Foods	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Medications	<input type="checkbox"/>	<input type="checkbox"/>	
Any dizziness, light-headedness or fainting associated with exercise within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	
Any unexplained, rapid or irregular heart beat within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Do any allergies require an EPIPEN Injection? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is an inhaler required and carried by adult? <input type="checkbox"/> Yes <input type="checkbox"/> No	Description of any limitation, restriction, physical condition or accommodation:					

Medication Name	Use	Dosage

Name of Insurance Co.: _____ Policy #: _____

CONSENT FOR MEDICATION ADMINISTRATION AND MEDICAL TREATMENT

By signing below,

- I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- I am stating that I am aware of and accept the risk inherent in the program activity.
- I attest that all information on this form is correct.
- I agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin–Extension, their officers, agents, and employees from any and all liability, loss, damages, costs, or expenses which are sustained, incurred or required arising out of my actions in the course of the event/camp.

Adult Participant Name (Please Print)
Adult Participant Signature
Date


An EEO/AA employer, University of Wisconsin-Extension provides equal opportunities in employment and programming, including Title IX and Americans with Disabilities Act (ADA) requirements.