

University of Wisconsin-Eau Claire

CONSENT FOR MEDICAL TREATMENT

TO THE PARENT(S) OR LEGAL GUARDIAN:

- If your son, daughter, or ward will be under the age of 18 years while at our camp/event, it is our policy to secure your consent for medical treatment.
- By Signing below you are giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- By signing below you are stating that you are aware of and accept the risk inherent in the program activity.
- By signing below you agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin-Eau Claire, their officers, employees and agents, from any and all liability, loss damages, or expenses which are sustained, or required arising out of the actions of your dependent in the course of the camp/event.

Participant Name – Please Print	Signature of Parent or Guardian	Date
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UWEC Photo Consent

I understand that the University may take photographs or video of participants and activities. I agree that the University of Wisconsin-Eau Claire shall be the owner of and may use such photographs and video relating to the promotion of future camps/events, presentations, and in any University Publication. I relinquish all rights that I may claim in relation to the use of said photographs.

Participant Name – Please Print	Signature of Parent or Guardian	Date
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This form should be completed in full. Please **return prior to the first day of the program session**. If you are unable to return it prior to your session, you **must** bring it with you to registration on the first day of the program session. **No student may attend this program without this form on file**. Please return, with designated signatures to:

UWEC Department of Kinesiology
Attn: Jeff Lindauer
McPhee Phy. Ed Center
UW-Eau Claire
Eau Claire, WI 54702-4004

PART TWO: HEALTH HISTORY QUESTIONNAIRE

Full Participant Name:	Social Security Number:	Name of Camp/Event	Camp Dates
Full Home Address:	Home Telephone Number:	Date of Birth: ____/____/____	Sex: M F
Parent/Guardian Name:	Relationship:	Height:	Weight:
Address (if different than above)	Home Telephone Number:(if different than above)	Does participant have allergic reactions to:	
	Parent/Guardian Work Telephone:	<input type="checkbox"/> Yes <input type="checkbox"/> NoPenicillin <input type="checkbox"/> Yes <input type="checkbox"/> NoOther Antibiotics _____ <input type="checkbox"/> Yes <input type="checkbox"/> NoOther Medicine (type) _____ <input type="checkbox"/> Yes <input type="checkbox"/> NoInsect Bites/Stings _____	
Alternate contact in the event that the Parent/Guardian cannot be contacted during an injury or illness. (Name, Relationship, Address, and Telephone Number)		Does participant take medication on a regular basis?	
Physician: _____ Telephone:_____		<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Identify _____ (consent for medication administration must be signed on reverse.)	
Insurance Co.: _____ Policy No.: _____		Has participant had or presently experiencing:	
		<input type="checkbox"/> Yes <input type="checkbox"/> No Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures/Blackouts <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Injury/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Menstrual Difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No Mental/Emotional Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Neck/Back Pain/Injury <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer Other: _____	
Immunization Record			
* MMR (measles, mumps, rubella)			
Dose 1-Immunization at age 1		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dose 2		<input type="checkbox"/> Yes <input type="checkbox"/> No	
* Tetanus-Diphtheria		<input type="checkbox"/> Yes <input type="checkbox"/> No	
* Year of last tetanus boost (must be within last 10 years)			
Has participant ever had major surgery or been hospitalized?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please explain any significant operations, accidents or illnesses, and last medical attention and reason:			
Does the participant have any physical condition(s) requiring special considerations? Explain.			
A physical examination within 24 months of the camp/event is recommended. Date of participant's last physical examination:_____			