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.

Child's Name – Please Print   Signature of Parent or Guardian   Date

---

UWEC Photo and Video 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.

Child's Name – Please Print   Signature of Parent or Guardian   Date

---

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 returnwith designated signatures to:

UWEC Department of Kinesiology
Attn: Yoosin Oh
McPhee Phy. Ed Center
UW-Eau Claire
Eau Claire, WI 5702-4004

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 Height: Weight:

Parent/Guardian Name:	Relationship:
Address (if different than above)	Home Telephone Number:(if different than above) Parent/Guardian Work Telephone:

Does participant have allergic reactions to:
❑ Yes ❑ No ....Penicillin
❑ Yes ❑ No ....Other Antibiotics ___________________
❑ Yes ❑ No ....Other Medicine (type) _____________
❑ Yes ❑ No ....Insect 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)

Physician: ____ Telephone:_____________________

Insurance Co.: _____________________________________ Policy No.: _______________

Does participant take medication on a regular basis?
❑ Yes ❑ No If Yes, Identify ________________________
(consent for medication administration must be signed on reverse.)

Immunization Record

* MMR (measles, mumps, rubella)	
Dose 1-Immunization at age 1	❑ Yes ❑ No
Dose 2	❑ Yes ❑ No
* Tetanus-Diphtheria	❑ Yes ❑ No
* Year of last tetanus boost (must be within last 10 years)	

Has participant ever had major surgery or been hospitalized? ❑ Yes ❑ 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:_________

Has participant had or presently experiencing:

❑ Yes ❑ No Allergies
❑ Yes ❑ No Asthma
❑ Yes ❑ No Bleeding Disorder
❑ Yes ❑ No Cancer
❑ Yes ❑ No Colitis
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Epilepsy/Seizures/Blackouts
❑ Yes ❑ No Heart Disease
❑ Yes ❑ No Hernia
❑ Yes ❑ No High Blood Pressure
❑ Yes ❑ No Joint Injury/Surgery
❑ Yes ❑ No Kidney Disease
❑ Yes ❑ No Menstrual Difficulties
❑ Yes ❑ No Mental/Emotional Problems
❑ Yes ❑ No Neck/Back Pain/Injury
❑ Yes ❑ No Rheumatic Fever
❑ Yes ❑ No Tuberculosis
❑ Yes ❑ No Ulcer
Other: ____