

University of Wisconsin– Extension

Adult Event Health Form

Event Name:		
Dates:		

Name:			Age:			Male	Female		
E-mail Address:									
Phone Numbers: Home () Work (_)		<u>-</u> C	ell ph	one () -			
Home Address:									
Street			City			State	Zip		
Emergency Contact:			Rela	tionsh	nip: _				
Primary Phone Number ()		Secondary Phone Number ()							
Address:									
Street						State	Zip		
Health Conditions (check)	Yes	No	Allergies (check)	Yes	No	List specifics			
Asthma			Insect stings						
Diabetes			Foods						
Epilepsy			Medications						
Any dizziness, light-headedness or fainting associated with exercise within the past year?			Other						
Any unexplained, rapid or irregular heart beat within the past year?			Do any allergies red	equire an EPIPEN Injection?					
Is an inhaler required and carried by adult? Description of any Yes No	limita	tion,		condi	tion (or accommodation:			
Medication Name		Use			Dosage				
Name of Insurance Co.:				Pol	icy #:				

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.