UNIVERSITY OF WISCONSIN – MILWAUKEE

2019 PROGRAM PARTICIPANT FORM

Event Name: _____

Event Dates: _____

Participant Name: _____ DOB: _____ Age on first day of event: _____ Gender: _____

Participant cell phone (landline if no cell): _____ Participant Email address: _____

Participant Home address: _____

If participant is under 18, custodial parent/ guardian name: _____ Cell phone: _____ Home or work phone: _____

Emergency Contact: Name: _____ Relationship: _____

Contact number: _____ Alternative contact number: _____

PLEASE READ THE FOLLOWING PARAGRAPHS CAREFULLY. IF YOU HAVE ANY QUESTIONS REGARDING THIS AGREEMENT OR WOULD LIKE TO NEGOTIATE ITS TERMS, CONTACT _____ AT _____.

ASSUMPTION OF RISKS

You are being asked to sign this form because you would like to participate in the above-listed event (the "Program") sponsored by the University of Wisconsin-Milwaukee ("UWM"). Before you can participate, UWM asks that you read this document carefully. If you want to ask questions about this document or request changes to it, you can do so by contacting the party listed above.

By participating in the Program, you are putting yourself at some risk (e.g., vehicle accident during field trip, harm by other participants, etc.). The specific risks vary from one activity to another, but resulting injuries can range from minor (e.g., scratches and bruises), to major (e.g., fractures and internal injuries), or catastrophic (e.g., paralysis and death). UWM recommends you minimize your risks by talking to a doctor before participating in the Program and carrying insurance (insurance is not provided by UWM).

Please sign here to indicate that you understand that risks are inherent in the Program and you **knowingly and willingly accept those risks.**

Signature of participant: _____ Signature of parent/guardian if participant is under 18: _____

Date: _____ Date: _____

WAIVER OF RIGHTS

In exchange for allowing you to participate in the Program, UWM asks that you agree not to make a claim against UWM if you are injured while participating in the Program, even if your injury was caused by UWM's negligence. This means you are giving up your right to sue UWM if you are injured during the Program. "Injury" refers to injuries to both your body and your property, whether caused by a UWM employee or a third party. You are not being asked to give up your rights in the event UWM acts recklessly or in an intentionally destructive manner.

Please sign here to confirm that y**ou are willing to give up your claims and rights against UWM in the event you are injured (including the right to sue).**

Signature of participant: _____ Signature of parent/guardian if participant is under 18: _____

Date: _____ Date: _____

HEALTH INFORMATION (CHECK ALL THAT APPLY TO PARTICIPANT)

- ☐ Asthma
  Is an inhaler required and carried by participant?
  ☐ Yes ☐ No
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Headaches
- ☐ Mental Health Conditions (Depression, Anxiety, ADHD/ADD, etc)
- ☐ Seasonal Allergies
- ☐ Cognitive/Developmental Concerns
- ☐ Any dizziness, light-headedness or fainting associated with exercise within the past year
- ☐ Any unexplained, rapid or irregular heart beat within the past year
- ☐ A physician has ever denied or restricted participation in sports due to a heart problem

- ☐ **No known drug or medication allergies**

KNOWN ALLERGIES TO (List):

- ☐ Medications _____
- ☐ Foods _____
- ☐ Insect stings _____
- ☐ Other _____

Do any allergies require an EPI PEN Injection?

☐ Yes ☐ No

Date of last Tetanus booster :
(Td or Dtap or DTP) _____

Description of any limitations or restrictions of program activities:

_____

Any special accommodations regarding physical or emotional conditions we need to be aware of regarding your participation in this program:

_____

MEDICATION INFORMATION

All medication brought to UWM must be in the original medicine packaging. Prescription medication must be labeled with the participant's name, doctor's name and phone number, medication name, dosage, prescription number, date prescribed, and instructions. Only the amount of medication necessary during the course of the event should be brought to UWM.

Participants 18 or older may carry over-the-counter ("OTC") and prescription medication during the event and will be expected to self-administer such medication.

If the participant will be under the age of 18 during the event, it is UWM policy to secure parental/guardian consent for prescription medication distribution and for the use of medical devices. With the exception of a limited amount of medication for life-threatening conditions (bee sting kit, inhaler, insulin syringe, etc.), all prescription medications and medical devices must, by law, by distributed by UWM staff. This does not include OTC medications such as allergy pills, aspirin, etc.

Please choose one of the following:

☐ No prescription medication will be brought to this event.

☐ The prescription medication listed below will be brought to the event.

Name of primary care provider: Phone number:

Medications

1	**Name of Medication:**	**Side effect experiences:**	**Prescriber's name and phone number:**
	Dosage of Medication:	**How is it taken? (mouth, injection, inhaled)**	
			☐ **AM** ☐ **Noon** ☐ **PM** ☐ **bedtime**
	Days to be taken:	**Reason taken?**	**Special Instructions**
2	**Name of Medication:**	**Side effect experiences:**	**Prescriber's name and phone number:**
	Dosage of Medication:	**How is it taken? (mouth, injection, inhaled)**	**When is it administered? Please check**
			☐ **AM** ☐ **Noon** ☐ **PM** ☐ **bedtime**
	Days to be taken:	**Reason taken?**	**Special Instructions**
3	**Name of Medication:**	**Side effect experiences:**	**Prescriber's name and phone number:**
	Dosage of Medication:	**How is it taken? (mouth, injection, inhaled)**	**When is it administered? Please check**
			☐ **AM** ☐ **Noon** ☐ **PM** ☐ **bedtime**
	Days to be taken:	**Reason taken?**	**Special Instructions**
4	**Name of Medication:**	**Side effect experiences:**	**Prescriber's name and phone number:**
	Dosage of Medication:	**How is it taken? (mouth, injection, inhaled)**	**When is it administered? Please check**
			☐ **AM** ☐ **Noon** ☐ **PM** ☐ **bedtime**
	Days to be taken:	**Reason taken?**	**Special Instructions:**

Participants, please sign here to indicate that the information above is true and correct:

_____ Date: _____

If the participant is under 18, parent/guardian, please sign here to indicate that (i) the above information is true and correct, and (ii) you consent to UWM staff distributing the participant's prescription medication as set forth above:

_____ Date: _____