University of Wisconsin-Whitewater
Health Information Form
UW-Whitewater Clinics

To be completed by Parent or Guardian, or participant if 18 years old or older

Participant's Name: _____ Date of Birth:_____

Home Address: _____ Gender: M F

Street/PO Box

_____

City/ State Zip

Parent/Guardian: _____

Home telephone: _____

Cell phone: _____

Health Insurance Carrier: _____

Policy Number: _____

1. Date of last tetanus shot: _____
2. Date of last MMR immunizations: _____
3. Does the participant have any significant allergies? Yes No
   If yes, please list: _____
   _____
4. Will the participant be taking any medications while attending our program? Yes No
   If yes, please list: _____
   _____
5. Doe the participant have any continuing health problems (diabetes, epilepsy, etc)? Yes No
   If yes, please describe:_____
   _____
6. Date of last physical exam: _____

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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 state of Wisconsin, the Board of Regents of the University of Wisconsin, and the University of Wisconsin-Whitewater, their officers, agents and employees, from any and all liability; loss, damage costs or expenses which are sustained, incurred, or required arising out of the actions of your dependant in the course of the event.

_____ _____

Parent/Guardian (or participant if 18 years old or more) Date