# MEDICAL DISCLOSURE AND ASSUMPTION OF RISK

**PROGRAM/DATES:**

**PARTICIPANT'S FULL NAME:**

The following medical information may be necessary in the event of serious illness or accident. Please complete this form accurately. The facts you disclose will be kept confidential and will be used only to help the staff respond to an injury or illness. Failure to disclose accurate and complete information could compound the seriousness of an accident or illness, particularly if you are unable to respond clearly to the medical staff's inquiries. Please print your responses.

**PERSON TO CONTACT IN EVENT OF EMERGENCY:**

Name: Relationship:

Home Phone: Email Address:

Cell Phone:

**MEDICAL INSURANCE:**
You must have medical/accident insurance that will cover the expenses of serious illness or accident. List below your medical/accident insurance provider:

**DIETARY RESTRICTIONS:**
Describe any dietary restrictions (i.e., lactose intolerant, food allergies)

**MEDICATIONS:** List all medications you are taking or will be taking during participation in this program. All medicines, prescribed or over-the-counter, must be transported in their original packaging.

**ASSUMPTION OF RISK:**

I have consulted with a medical doctor regarding my personal medical needs. I am aware of my personal medical needs.

I assume all risk and responsibility for my medical needs.

There are no health-related reasons or problems that preclude or restrict my participation in this program.

The University may, but is not obligated to, take any actions it considers to be warranted under the circumstances regarding my health and safety. I agree to pay all expenses relating thereto and release the University from any liability for its actions.

Signature of Participant: _____ Printed Name _____ Date
Participant's Signature

Signature of Parent or Guardian if participant is a minor: _____ Printed Name _____ Date
Parent/Guardian's Signature

_____ Printed Name _____ Date
Parent/Guardian's Signature