

# MEDICAL DISCLOSURE STATEMENT AND ASSUMPTION OF RISK

<b>PROGRAM:</b>		<b>DATES:</b>	
<b>PARTICIPANT:</b>			

The following medical information may be necessary in the event of serious illness or accident. Please complete this form accurately and to the best of your ability. 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:		Mobile Phone:	
Office Phone:		Email:	

**DIETARY RESTRICTIONS**

Please describe any known dietary restrictions (i.e., lactose intolerant, food allergies)

**MEDICATIONS**

Please list all medications you are taking or will be taking during this program. All medicines, prescribed or over-the-counter, should be transported in its original packaging.

**BLOOD TYPE RH FACTOR (IF KNOWN)**

**ASSUMPTION OF RISK**

I have consulted with a medical doctor with regards to my personal medical needs. I am aware of all applicable personal medical needs. I have no health related reasons or problems that preclude or restrict my participation in this program. I assume all risk and responsibility for my medical needs.

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 their actions.

Participant's Name:	Signature:	Date:
Parent/Legal Guardian's Name if participant is a minor:	Signature:	Date:
Parent/Legal Guardian's Name (2) if participant is a minor:	Signature:	Date: