



UNIVERSITY OF NORTH CAROLINA WILMINGTON

PARTICIPANT INFORMATION AND MEDICAL RELEASE LONG FORM

Program registering for _____

Name of Participant _____

Male Female

Date of Birth: ____/____/____

Parent/Guardian Name (*if applicable*) _____

Home Address _____

City _____ State _____ Zip _____

Day Phone (____) _____ Evening Phone (____) _____

Parent/Guardian Email (*print clearly*) _____

Alternate Emergency Contacts:

Primary (*Name*) _____ Relationship _____ Phone # (____) _____

Secondary (*Name*) _____ Relationship _____ Phone # (____) _____

If the student must leave the program for any reason and you cannot be reached, there must be another adult available who will take responsibility for removing the student from the campus.

Name(s) of adult(s) other than parent/guardian authorized to act on your behalf in this situation:

Name _____ Phone #(s) (____) _____

Name _____ Phone #(s) (____) _____

Physician or clinic you usually consult for medical care:

Name _____ Phone #(s) (____) _____

Medical Information:

Date of last tetanus immunization ____ / ____ / ____

Allergies: _____

Drug Sensitivities _____

Current medical/psychological problems being treated _____

Current restrictions/recommendations due to medical condition(s) _____

Current medications, reason for taking _____

What accommodations should be made to insure proper administration and storing of the medication? _____

Past medical/psychological problems staff should be aware of _____

Is an identification band or card carried to alert others to the allergy(ies), medical conditions or medication use?
 Yes No

Do you have any health concerns about your child participating in this activity?

Yes No (check one)

If yes, please elaborate:

The Program's activities may inhibit or prevent participation. If any of these conditions pertain to you, you may VOLUNTARILY indicate by circling the information below. (Information will be shared ONLY with pertinent Program staff or medical professionals).

1. Motion sickness	12. Diabetes	23. Hay fever
2. Hospitalized	13. Tuberculosis	24. Asthma
3. Serious Injury	14. Bronchitis	25. Trouble equalizing pressure in sinuses/ears
4. Back problems	15. Claustrophobia	26. Frequent colds or sore throat
5. Physical handicap	16. High blood pressure	27. Severe or frequent headache
6. Regular medication	17. Respiratory problems	28. Ear or hearing problems
7. Allergies, including drugs	18. Persistent cough	29. Alcohol or drug problems
8. Dizziness or fainting	19. Pregnant	30. Mental or emotional problems
9. Epilepsy	20. Chest pains	31. Current communicable disease
10. Heart trouble	21. Contact lenses	32. Rejected from an activity for medical reasons
11. Sinus trouble	22. Dental plates	33. Any medical problem not listed

Knowing these risks, are you/is your child capable of participating? Please answer if you will/she/he may participate. Yes No

Clearly print or type remarks: _____

I agree to notify the camp director by the registration deadline of any change that may occur in his/her physical or mental health prior to arrival at the Program or in the course of his/her attendance there.

Swimming Level: Unable to Swim Weak Average Strong (check one)

You/Your child will not be allowed to participate unless covered by your own health insurance policy during the period that you/your child will be participating in the Program.

Do you have such coverage? Yes No

(At the sole discretion of the Program, proof of insurance may be required before participation in the UNCW Youth Programs program.)

Insurance Company's Name _____

Medical/Hospitalization Insurance Policy # _____

Phone Number of Office Holding Policy (_____) _____

- **I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.**

- **I AUTHORIZE THE ABOVE LISTED ADULT(S) TO TAKE CHARGE OF THE STUDENT IF HE OR SHE MUST LEAVE THE PROGRAM AND I CANNOT BE REACHED.**

STUDENT'S SIGNATURE

DATE

CUSTODIAL PARENT'S OR GUARDIAN'S SIGNATURE *(Signature of one parent binds both parents)*

DATE

PRINTED NAME OF PARENT

PRINTED NAME OF CHILD