

**THIS FORM IS TO BE COMPLETED FOR ANY CONFERENCE PARTICIPANT UNDER THE AGE OF 18. PLEASE NOTE: CONFEREES MAY NOT UTILIZE OUR HEALTH CENTER FACILITY WITHOUT THIS COMPLETED FORM.**

**KUTZTOWN UNIVERSITY  
OFFICE OF CONFERENCE SERVICES  
HEALTH HISTORY/MEDICAL TREATMENT PERMISSION FORM**

Name of conferee \_\_\_\_\_ Birth date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Parent or Guardian \_\_\_\_\_

Home address \_\_\_\_\_ Phone \_\_\_\_\_

Business address \_\_\_\_\_ Phone \_\_\_\_\_

Other Emergency Contact \_\_\_\_\_

Home address \_\_\_\_\_ Phone \_\_\_\_\_

Business address \_\_\_\_\_ Phone \_\_\_\_\_

Name of conference attending \_\_\_\_\_ Date of conference \_\_\_\_\_

**Health History:** (give dates)

Heart Defect/Disease \_\_\_\_\_  
Convulsions \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Hypertension \_\_\_\_\_  
Mononucleosis \_\_\_\_\_  
Bleeding/Clotting Disorder \_\_\_\_\_  
Frequent Ear Infections \_\_\_\_\_

**Diseases:** (give dates)

Chicken Pox \_\_\_\_\_  
Measles \_\_\_\_\_  
German Measles \_\_\_\_\_  
Mumps \_\_\_\_\_

**Allergies:** (give dates)

Hay Fever \_\_\_\_\_  
Ivy Poisoning \_\_\_\_\_  
Insect Stings \_\_\_\_\_  
Penicillin \_\_\_\_\_  
Other drugs \_\_\_\_\_  
Asthma \_\_\_\_\_

Operations or serious injury (dates): \_\_\_\_\_

Disability or chronic recurring illness: \_\_\_\_\_

Dietary modifications: \_\_\_\_\_

Current medication taking: \_\_\_\_\_

Do you carry family medical/hospital insurance? \_\_\_\_\_ Carrier \_\_\_\_\_ # \_\_\_\_\_

I, the undersigned parent/guardian, do hereby grant permission for my son/daughter, named above, to attend the conference named above. In order that my son/daughter may receive the proper medical treatment in the event that he/she may sustain injury or illness during the period of the above conference, I hereby authorize the conference staff and the Kutztown University Health Center to obtain or provide medical treatment for my son/daughter for such injury or illness during the conference, and I hereby hold the University, as well as its representatives, harmless in the exercise of this authority.

I further understand that there is always a possibility that my son/daughter may sustain physical illness or injury while at a conference at Kutztown University. If this occurs, I hereby authorize conference staff and Kutztown University Health Center and Kutztown University representatives to refer my son/daughter to a medical treatment center (hospital, etc.). I further acknowledge and understand that I will be responsible for any medical bills that may be incurred on behalf of my son/daughter for physical illness or injury that he/she may sustain during the conference.

Understanding that there is always a possibility that my son/daughter may sustain physical illness or injury, I acknowledge and understand that my son/daughter is assuming the risk of such physical illness or injury by his/her participation, and I further release Kutztown University Foundation and its representatives and Kutztown University and its representatives from any claims for personal illness or injury that my son/daughter may sustain during the conference. I further acknowledge and understand that my son/daughter will be responsible for his/her failure to abide by the rules and regulations of the conference named above or of Kutztown University.

Signed \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

**THIS FORM IS TO BE RETURNED TO YOUR CONFERENCE COORDINATOR,  
NOT KUTZTOWN UNIVERSITY PERSONNEL OR OFFICES**

**THIS FORM IS TO BE COMPLETED BY PARTICIPANTS  
ATTENDING ANY KUTZTOWN UNIVERSITY  
SPONSORED CAMP/CONFERENCE/CLINIC/EVENT.**

**Informed Consent Release  
and  
Express Assumption of Risk**

I, \_\_\_\_\_, desire to participate in \_\_\_\_\_  
(Name) (Name of Summer Camp or Conference Event)  
at Kutztown University on \_\_\_\_\_.  
(Date of Event)

I realize injuries can be a consequence of participation in this activity and no amount of reasonable supervision or use of facility will prevent injury. I appreciate the character of the risk involved and I voluntarily assume (on behalf of my child if participant is a minor) all risk of possible death, harm or injury. I understand and appreciate that such injury could also include, without limitation, serious or permanent injuries to all bodily organs and functions. I am aware of the risk of participation in this designated activity. I have carefully considered how the possible consequences of injury may impact my life (or my child's life), and I choose to accept the risk involved (and allow him/her, if minor child) to participate in the designated activity.

In accepting this risk, I expressly and explicitly release, discharge and waive any and all responsibility of Kutztown University, Pennsylvania's State System of Education, the Commonwealth of Pennsylvania, and the employees, officials or agents of any and all of the foregoing, pursuant to, or pertaining or related to, arising from, in any manner, injuries to myself (my child) as a result of my (his/her) participation in this activity.

By my signature below, I certify that I completely understand this document.

\_\_\_\_\_  
Signature of Participant Date

\_\_\_\_\_  
Signature of Parent or Guardian (if participant is a minor) Date

\_\_\_\_\_  
Witness Date