Acknowledgment of Risk Form

Participant: _____

Event/Activities: _____

Dates: _____

Location: _____

1) IN CONSIDERATION of the right to attend and participate in the Activities described above, the Participant (and, if the Participant is a minor, his or her parent or legal guardian) hereby:

2) Agrees to abide by all rules and regulations established by the Wisconsin Leadership Seminars Inc. (WILS).

3) Authorizes WILS or any of its agents to provide, obtain, or authorize any reasonable incidental and/or emergency medical treatment for the Participant, in the event of the Participant's illness, injury, or incapacity, and hereby accepts the responsibility to pay for such treatment;

4) Grants to WILS for any purpose connected with promoting the purposes and goals of WILS, but not for commercial exploitation, the right to use the Participant's name, voice, and likeness in any writings, photographs, films, and recordings of the Participant while he or she is participating in the Activities, and any biographical information submitted by the Participant to WILS, and to use, reproduce, publish, and distribute the same;

5) Acknowledges that there is an element of risk involved in any activity involving travel outside of one's own home or community; certifies that the Participant is physically, mentally, and emotionally capable of attending and participating in the Activities; assumes all risk of and financial responsibility for any loss or injury to the Participant or others that may occur as a result of the Participant's negligence or misconduct; and indemnifies and holds WILS harmless from and against any and all costs, claims, demands, charges, liabilities, obligations, judgments, executions, costs of the suit and actual attorneys' fees incurred or suffered by WILS as a result of, or arising out of, the Participant's negligence or misconduct;

6) The Participant (and, if the participant is a minor, his or her parent or legal guardian) has read this Consent and Acknowledgment of Risk, and understands its contents.

_____ _____

Signature of Participant **Date**

Name of Parent or Legal Guardian:

_____

Street Address:_____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

_____Date: _____

Signature of Parent or Legal Guardian

Heath Insurance Form

(please type or print legibly)

1. Name of Participant _____

2. Health insurance plan name * _____

3. Health insurance plan number _____

4. ☐ Check here if participant is not covered by a health insurance plan

5. Name of policy hoder _____
   last first

6. Policy holder Social Security #: _____

7. Policy holder Date of Birth: _____

8. Emergency contact telephone number _____
   (area code)

Signature of policy holder _____

* This information will be given to a medical facility or doctor in the event of illness or injury during the leadership seminar

WISCONSIN LEADERSHIP SEMINARS INC.
A TRAIL SEMINAR

Record of Medical History

Dear Participant: For our records, and for your protection, please complete this form in its entirety. Please provide ALL requested information and obtain the signature of your parent or legal guardian.

PERSONAL INFORMATION

(Last Name) (First Name) (Middle Initial)

Circle one: Male Female

Social Security Number

Date of Birth

Place of Birth

(Area Code) Telephone Number

High School / Institution You Represent

Permanent Street Address

City State Zip Code

EMERGENCY CONTACT INFORMATION

(Last Name) (First Name)

Relationship to Student /Participant

(Area Code) Primary Telephone Number

(Area Code) Secondary Telephone

Name of Family Physician

(Area Code) Physician Telephone Number

PERSONAL MEDICAL HISTORY

Please check the following diseases you have had in the past:

☐ Bleeding Tendencies	☐ German Measles	☐ Polio
☐ Chicken Pox	☐ Heart Disease	☐ Pneumonia
☐ Diphtheria	☐ Measles	☐ Rheumatic Fever
☐ Diabetes	☐ Mononucleosis	☐ Tonsilitis
☐ Epilepsy	☐ Mumps	

☐ OTHER:

Please check the following conditions you have had or are subjet to now:

Ear Infection	☐	Nose Bleed	☐	Convulsions	☐
Hay Fever	☐	Hearing Loss	☐	Dizzy Spells	☐
Headache	☐	Vision Loss	☐	Fainting Spells	☐
Migraine	☐	Upset stomache	☐	Difficulty Sleeping	☐

☐ OTHER:

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What treatments or medications (if any) do you require for any of the conditions from the previous page?

_____

_____

Are there any past hospitalizations or illnesses we should be aware of?

_____

_____

Please list all allergies excluding medications (insect stings, plants, foods, etc)

_____

_____

MEDICATION

Please list any medications you have allergic reactions to (penicillin, sulfa drugs, tetanus antitoxin, etc):

_____

_____

Please list any medication you are taking, the dosage, and the condition that requires you to take the medication:

_____

_____

Please list any dietary considerations you have:

_____

_____

IMMUNIZATIONS

Please check the type of illnesses you have received immunizations for:

Type of Illness:	**Approximate Date of Immunization:**
☐ Mumps	_____
☐ Regular Rubella Measles	_____
☐ Whooping Cough	_____
☐ Influenza / Colds	_____
☐ Typhoid	_____
☐ Diphtheria	_____
☐ Smallpox	_____
☐ Tetanus	_____
☐ Polio Series	_____
☐ Pneumonia	_____

GENERAL

If there are any limitations on the amount of physical exercise you can engage in, please describe and explain: (use additional sheet of paper if necessary)

_____

_____

_____ _____

Signature of Participant **Signature of Parent or Legal Guardian**

Date: _____