Complete these forms and give them to your student's teacher!

Science Adventure School – WVU
Participant Information Form

- **Please write *legibly* and in *pen*.**
- **Please answer the following questions honestly and accurately. This information will be kept confidential.**
- **Our goal is to provide you with the best experience possible, making accommodations where needed.**
- **Please contact us for questions or concerns about any of the following items.**
- ***Please notify us of any changes that happen between completing this form and the start of your program.***

PARTICIPANT INFORMATION

Last Name: _____ First Name: _____

Height: _____ Weight: _____ Gender: _____ Date of Birth: _____/_____/_____

Age: _____ Street Address: _____ T-shirt Size:_____

City/State/Zip: _____ Home Phone: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact #1: _____ Relationship: _____

Cell Phone: _____ Home: _____ Work: _____ Email: _____

Emergency Contact #2: _____ Relationship: _____

Cell Phone: _____ Home: _____ Work: _____ Email: _____

INSURANCE INFORMATION

Each participant is responsible for medical expenses. A copy of your current medical insurance card should be brought along with you on the program.

Name of Insurance Company: _____ Insurance Co. Phone: _____

Group #: _____ Name on Insurance Card: _____

ALLERGY INFORMATION

Do you have any ALLERGIES? ____ YES ____ NO

If YES, do you carry epinephrine, such as an Epi-Pen? ____ YES ____ NO

If YES, Have you ever been hospitalized for these allergies? ____ YES ____ NO

Describe your allergies, including severity and other pertinent information: _____

_____

_____

Complete these forms and give them to your student's teacher!

DIETARY INFORMATION

Please mark dietary restrictions, needs, and requests here. ***If it is not listed on this form, we cannot accommodate it.***

Do you have any DIETARY RESTRICTIONS (i.e. vegetarian, lactose-intolerant, etc.)? ____ YES ____ NO

Describe your dietary restrictions, including foods avoided and other pertinent information: _____

_____

OTHER PERTINENT HEALTH INFORMATION

Please list any other pertinent health information that may affect your ability to participate in this program, including recent injuries, pre-existing health conditions, etc.:

_____

_____

MEDICATIONS

If you are taking any medication that may be required during the program, you must bring all of those with you. If you do not have them, you may not be allowed to participate in the program.

Please list all medications, if not taken, that may affect your ability to participate in the program: _____

_____

_____

OTHER

If you regularly use any brace, orthotic, or other device, please bring this device with you. If you do not have them, you may not be allowed to participate in the program.

Please list any brace, orthotic, or other device that you use regularly: _____

_____

_____

VISION/HEARING CORRECTION

Please bring any vision or hearing corrective items with you. If you wear contacts, please bring glasses in addition.

Do you wear glasses, contacts, hearing aids, or use other implements to correct vision/hearing? ____YES ____NO

PHYSICIAN INFORMATION

Physician's Name: _____ Phone: _____

ACCURACY STATEMENT

I hereby state, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of Participant: _____ Date: _____

Signature of Parent/Guardian (Required if under 18): _____ Date: _____