Participation Form

Please complete all items. If response is not applicable, please mark N/A.

Name_____ Birth Date____/____/____ ❑ Male ❑ Female
Last First Month / Day / Year

Primary Emergency Contact_____ County_____
Home Address_____ Home Phone ( )_____
City St Zip_____ Work Phone ( )_____
E-mail_____ Cell Phone ( )_____
Alternate Emergency Contact_____Phone ( )_____

Name of Family Doctor_____ Phone ( )_____
Health Insurance Company_____Policy No._____
Name of Insured_____Relationship to Participant_____

Health History

Does the participant have, or at any time has had, any of the following? Check "Yes" or "No" to each item. Please explain any "yes" answers (noting the number of the item) in the space below or on an additional sheet of paper if necessary. Reporting conditions will not prevent a person from attending and will be kept confidential.

	Yes	No
1) Asthma	❑	❑
2) Bronchitis	❑	❑
3) Convulsions	❑	❑
4) Diabetes	❑	❑
5) Ear Infection	❑	❑
6) Fainting	❑	❑
7) Heart Condition	❑	❑
8) Headaches	❑	❑
9) Hypoglycemia	❑	❑
10) Serious Insect Stings	❑	❑
11) Wear Glasses	❑	❑
12) Wear Contact Lenses	❑	❑
13) Other Conditions	❑	❑
14) Penicillin Allergy	❑	❑
15) Aspirin Allergy	❑	❑
16) Tetanus Allergy	❑	❑
17) Other Drug Allergies	❑	❑
18) Food Allergies	❑	❑
19) Serious Ivy, Oak or Sumac Poisoning	❑	❑
20) Other Allergies	❑	❑

Please explain "Yes" Answers and provide information on recent medical issues (including injuries and surgeries), allergic reactions, special dietary regulations, present medications, and any other comments.

_____

_____

_____

_____

_____

_____

Date of Last Tetanus Shot____/____/____

The following over-the-counter medications may be administered:

❑ Antihistamine ❑Antacid ❑ Ibuprofen (Advil) ❑ Acetaminophen (generic, Tylenol)
❑ Decongestant ❑ Dramamine ❑ Hydrocortisone ❑ Polysporin (topical antibiotics)
❑**Please contact me for permission to administer any over-the-counter medications.**

VERIFICATION

I,_____ (adult participant) understand participants will be supervised and that, if serious illness or injury develops, medical and/or hospital care will be given. I hereby give my permission to the attending physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child or myself and affirm that the information set forth in the Health History is true and correct to the best of my knowledge and belief.

Adult Participant Signature _____ Date _____

I hereby release Extension Master Gardeners, local extension boards, Kansas State University, the State of Kansas, and their agents, officers and employees, from all claims, demands, and causes of action of any kind, including claims of negligence, which may arise from participation of me in any Extension Master Gardener sponsored activity, and this release is specifically granted in consideration of the services, programs and activities, provided by K-State Research and Extension, and being allowed to participate.

Adult Participant Signature _____ Date _____