

**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**