

**EMPORIA STATE UNIVERSITY**  
**STATEMENT OF INFORMED CONSENT FOR PARTICIPATION AND**  
**PERMISSION TO PROVIDE EMERGENCY MEDICAL SERVICES**

**WARNING: ASSUMPTION OF RISK:** I, \_\_\_\_\_, the undersigned, hereby give my permission for myself to participate in (name of activity) \_\_\_\_\_. As I sign, I know that vigorous physical activity presents certain dangers of mild, moderate, or severe injury to myself. Further, as I sign, I know catastrophic injuries causing death, permanent paralysis or loss of organs can occur as a result of physical activity. I acknowledge that the entity sponsoring the above named activity, Memorial Union, and Emporia State University officials, do not have control over these dangers.

**PERMISSION TO PARTICIPATE:** I, the undersigned, state that to the best of my knowledge my child is physically capable of participating in a vigorous daily schedule along with rigorous physical activity. Also, I verify the medical history following is complete and identifies any factors which might limit my physical activity. I hereby release Emporia State University, the Memorial Union Corporation, the State of Kansas, their employees and agents from any liability or claims arising from this activity, except as such claim may be made under the Kansas Tort Claims Act.

**PERMISSION FOR MEDICAL TREATMENT:** I, the undersigned, hereby give permission for myself to receive emergency medical treatment or transfer to appropriate medical facility as deemed appropriate by attending physician. Further, I acknowledge reading and understanding the above statements and truthfully completing the medical history portion of this form.

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL HISTORY**

Name \_\_\_\_\_ S.S.# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Emporia Address \_\_\_\_\_

Emergency Contact:

1) Parent/Legal Guardian/Spouse \_\_\_\_\_ Telephone \_\_\_\_\_

Full Address \_\_\_\_\_

Home Telephone \_\_\_\_\_ Business Telephone \_\_\_\_\_

2) Family Physician \_\_\_\_\_ Telephone \_\_\_\_\_

YES NO 1. Allergies \_\_\_\_\_

YES NO 2. Current Medication \_\_\_\_\_

YES NO 3. Major Medical Illness (e.g., anemia, diabetes, epilepsy, bleeding disorders, thyroid, etc.) \_\_\_\_\_

YES NO 4. Heart Conditions (murmur, heart disease) \_\_\_\_\_

YES NO 5. Respiratory Conditions (asthma, hay fever) \_\_\_\_\_

YES NO 6. Been Knocked Unconscious, How Often, Dates, Recommendation \_\_\_\_\_

YES NO 7. Has There Ever Been a Medical Problem with the Following (Please Check All That Apply):  
Eyes\_\_\_\_ Kidneys\_\_\_\_ Ears\_\_\_\_ Hernias\_\_\_\_ Testicles

YES NO 8. Operation or Surgery \_\_\_\_\_

YES NO 9. Fractures (broken bones) \_\_\_\_\_

YES NO 10. Have You Ever Fainted During Exercise? Explain \_\_\_\_\_

YES NO 11. Do You Have All Your Organs? If Not, Which Ones Are Missing? \_\_\_\_\_

YES NO 12. Overnight Hospitalizations? Explain \_\_\_\_\_

**MEDICAL INSURANCE**

Do you have medical insurance? YES NO Covered by: Parents Policy?\_\_\_\_\_ Own Policy? \_\_\_\_\_

Name of Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Company Address \_\_\_\_\_

STATE OF KANSAS

COUNTY OF LYON

Witness this \_\_\_\_\_ day of \_\_\_\_\_, A.D. 2000

Individual Signature \_\_\_\_\_

Associated Student Government

Firm Name Here

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, A.D. 2000, in testimony whereof, I have hereunto set my hand and official seal the day and year aforesaid.

Notary Public \_\_\_\_\_

My term expires: \_\_\_\_\_