

**University of Wisconsin-La Crosse
Adult Therapeutic Physical Fitness Program**

*****Emergency Release Form*****

NAME OF PARTICIPANT _____

Please complete Section 1 if the participant fully understands the intent of this emergency release form. Please complete Section 2 if the participant does not fully understand the intent of this emergency release form. Section 3 must be completed.

Section 1

I, the participant named above, give permission to receive emergency medical care in case of injury that may occur during the Adult Therapeutic Physical Fitness Program. I will not hold the university or personnel involved in this program legally responsible for any injury that may occur.

Signed _____ Date _____
Participant

Signed _____ Date _____
Witness

Section 2

As legal guardian/parent of the participant named above, I give permission for the above-named individual to receive emergency medical care in case of injury that may occur during the Adult Therapeutic Physical Fitness Program. I will not hold the university or personnel involved in this program legally responsible for any injury that may occur.

Signed _____ Date _____
Parent/Legal Guardian

Signed _____ Date _____
Witness

Section 3 *(All information must be provided)*

In the event of emergency situation, the participant named above is to be taken to:
_____ Emergency Room.

Hospital Emergency Room / Medical Facility

The participant's doctor is _____ Phone _____
Address _____

Emergency Contact: Name _____ Phone _____
Address _____

(continued on other side)

**University of Wisconsin-La Crosse
Adult Therapeutic Physical Fitness Program**

*****Consent For Photographs, Movies or Television*****

I, the undersigned, hereby authorize photographs and/or movies of _____
(the participant), by representatives of the Adult Therapeutic Physical Fitness program staff in
contributing to the educational development of this staff and the advancement of teaching
techniques and program activities.

Signed _____ Date _____
Participant or Parent/Legal Guardian

Signed _____ Date _____
Witness

I further agree that the Adult Therapeutic Physical Fitness program may use or permit other
persons to use the negatives or the prints prepared therefrom for any such educational purposes
and in such manner as may be deemed beneficial and necessary. It is understood that the
individual's name will not be visible or audible during such usage unless permitted by the
undersigned.

Signed _____ Date _____
Participant or Parent/Legal Guardian

Signed _____ Date _____
Witness