



<b>Office Use Only</b> Date Received: _____
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## Summer Bike Camp Application

### Participant Information Enrollment Form

To Parent/Legal Guardian: To participate in the Summer Bike Camp at UW-La Crosse, please complete this form as accurately as possible. All information is necessary to maximize safety and will be kept confidential. Please use the back of the page if you need more space.

Participant's name \_\_\_\_\_ Gender:  M  F

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ T-shirt size \_\_\_\_\_

Parent/Guardian name \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

Parent/Guardian address \_\_\_\_\_

Parent/Guardian phone \_\_\_\_\_

Parent/Guardian e-mail \_\_\_\_\_

#### Emergency contact (In case parent(s)/guardian(s) cannot be reached):

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to participant \_\_\_\_\_

School \_\_\_\_\_ Phone \_\_\_\_\_

Adapted Physical Education Teacher (include phone #) \_\_\_\_\_

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Hospital \_\_\_\_\_

Primary disability of Participant \_\_\_\_\_

Secondary disability (if appropriate)  
\_\_\_\_\_

Relevant medical concerns \_\_\_\_\_

\_\_\_\_\_  
Parts of body affected (describe) \_\_\_\_\_

\_\_\_\_\_  
Body movements that should be avoided (describe) \_\_\_\_\_

\_\_\_\_\_  
Is the participant ambulatory?  YES  NO

Does the participant use any braces, wheelchair, or other special equipment? If so, what?  
\_\_\_\_\_

Medications Taken	What for	Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does the participant have allergies? (**Including latex**)  YES  NO  
If yes, please list

\_\_\_\_\_  
How are allergies controlled?  
\_\_\_\_\_

Does the participant have seizures?  YES  NO If yes, type(s) of seizure & how long they usually last:  
\_\_\_\_\_

How are the seizures controlled? \_\_\_\_\_

Controlled by medication? (Please list) \_\_\_\_\_

How often do they occur? \_\_\_\_\_ Date of last seizure \_\_\_\_\_

How does the participant communicate? (describe)  Verbal  Nonverbal  
\_\_\_\_\_

Has the participant participated in two-wheel bike riding before?  YES  NO If yes, where and when?

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**General Behavioral Characteristics** (check those applicable)

- Self-stimulatory     Withdrawn     Self-abusive     Amiable  
 Generally, calm     Easily frustrated     Aggressive     Subject to physical outbursts

Briefly describe the participant's personality and behaviors: \_\_\_\_\_

\_\_\_\_\_

Does the participant have any behavioral issues?  YES  NO If yes, please describe.

\_\_\_\_\_

How are these issues best dealt with?

\_\_\_\_\_

\_\_\_\_\_

Please list interests of your child and things that motivate your child: \_\_\_\_\_

\_\_\_\_\_

Do you have any ideas or suggestions that may be helpful when interacting with your child?

\_\_\_\_\_

\_\_\_\_\_

**On the backside of this page, please add any other important information that would be helpful to maximize safety and to create a positive experience for the participant.**

If the participant has any significant medical conditions, please attach a copy of the most current relevant medical report.

Name of individual providing information \_\_\_\_\_

Phone \_\_\_\_\_ date \_\_\_\_\_

Email \_\_\_\_\_

Means of transportation to the program and adult who will be staying during the session (please list phone number)

\_\_\_\_\_ Phone \_\_\_\_\_



## Summer Bike Camp Emergency Release Form

Name of Child (please print) \_\_\_\_\_

As legal guardian/parent, I give permission for the above-named individual to receive emergency medical care in case of injury that may occur during the Summer Bike Camp. I agree to defend, hold harmless, indemnify, and release the Board of Regents of the University of Wisconsin System, the University of Wisconsin-La Crosse, and their officers, employees, agents, and volunteers, from and against any and all claims, demands, actions, or causes of action of any sort on account of damage to personal property, or personal injury, or death which may result from participation in the above-listed program.

\_\_\_\_\_  
Parent or Legal Guardian                      Signature                      Date

Should my child be involved in an emergency, she/he is to be taken to the:

\_\_\_\_\_ Emergency Room.  
(Hospital/Clinic Name)

My family doctor is \_\_\_\_\_

If I cannot be reached, please contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Relationship to child \_\_\_\_\_

Center on Disability Health & Adapted Physical Activity  
108 Mitchell Hall; 1725 State St  
La Crosse, WI 54601  
Office Phone: 608-785-8690  
scoron@uwlax.edu



Copy and reuse form as needed

I/We hereby confer upon the University of Wisconsin-La Crosse, the University of Wisconsin-La Crosse Alumni Association and the University of Wisconsin-La Crosse Foundation the unrestricted and irrevocable right and permission with respect to the photographs and/or video taken of me or my children or in which we may be included with others:

- a) To use, reuse, publish and republish the same intact or in part, separately or in conjunction with other photography, in any medium now and hereafter known, and for any purpose whatsoever (including illustration, promotions, advertising and trade) and.
- b) To use my name and any testimonial I have provided to the university in connection therewith if UWL so decides.

I/We hereby release and discharge the photographer and/or videographer and the University of Wisconsin-La Crosse, the University of Wisconsin- La Crosse Alumni Association and the University of Wisconsin-La Crosse Foundation, from all and any claims and demands ensuing from on or in connection with the use of the photographs including any and all claims for libel and invasion of privacy.

I/We have read the foregoing and fully understand the contents hereof.

\_\_\_\_\_  
(Subject's name and signature) Phone Number (Date)

*When securing releases from multiple subjects it is acceptable to use one release form signed by all relevant persons. You may use the back of this form for additional signatures.*

**PHOTOGRAPHY AND VIDEOGRAPHY RELEASE OF MINOR(S)**

I have read the foregoing and fully understand the contents hereof. I represent that I am the (parent/guardian) of the below named subjects. I hereby consent to the foregoing on his/her behalf.

Name of Parent or Guardian \_\_\_\_\_ Minor Name(s) \_\_\_\_\_

\_\_\_\_\_  
(Parent or Guardian Signature)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

\_\_\_\_\_  
(Witness Name and Signature) (Date)

For office use: Photo and Video/Testimonial used for _____
Photographer/Videographer _____