

# Hooper Youth Program 2009 Registration

For each registrant, remove this entire sheet and complete: 1. Youth Registration (below) 2. Release of Liability and Treatment Authorization 3. Health Assessment.

Youth's name (use nickname) \_\_\_\_\_ Birthdate \_\_\_\_\_ Age as of 6/1/09 \_\_\_\_\_

Parent's or guardian's name \_\_\_\_\_

Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Email \_\_\_\_\_

Parent's or Guardian's Employer (optional to facilitate Youth Program support) \_\_\_\_\_

What experience does your child have with this activity? (Also list Hooper experience) \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Please circle your choices:**

**Sailing 1:** A-S10, A-S11, B-S10, B-S11, C-S10, C-S11, D-S10, D-S11, ES10, E-S11

**Sailing 2:** A-S21, B-S20, C-S21, D-S20, E-S21

**Sailing 3:** A-S30, B-S31, C-S30, D-S31, E-S30

**Sailing Day Camps:** A-X10, A-X11, B-X10, BX11, C-X10, C-X11, D-X10, D-X11, E-X10, E-X11, F-X10

**Advanced Sailing Day Camps:** A-X21, B-X21, C-X20, D-X20, D-X21, E-X20, E-X21, F-X20

**Beginning Racing:** A-R01, C-R01, D-R01, F-R01

**Windsurfing:** A-W10, B-W10, B-W11, C-W10, C-W11, D-W10, D-W11, E-W10, E-W11

**Windsurfing Intro:** B-W00, C-W00, D-W00, E-W00, F-W00

**Intermediate Windsurfing:** B-W01, C-W01, D-W01, E-W01, F-W01

**Advanced Windsurfing:** B-W21, C-W21, D-W20, E-W21

**Canoeing/Kayaking:** A-K11, B-K10, B-K11, C-K10, C-K11, D-K10, D-K11, E-K10, F-K10, F-K11

**Advanced Kayaking:** C-K20, E-K21

**Summer Racing Series:** R1, R2

**Open Sailing/Windsurfing:** OPEN

**Mentorship:** A-M10

**Sailing for Parents:** B-P10, C-P10, E-P10

**One of the following two sections must be completed with current ID #s or registration cannot occur:**

1. \_\_\_\_\_  
Current student, faculty or staff ID (circle one)

\_\_\_\_\_ Current faculty or staff department

2. \_\_\_\_\_  
Wisconsin Union membership #  
(Write "Intro" if first time union member. Cost is \$30.)

Type of Union membership:

Life  Annual  Intro Exp. date \_\_\_\_\_

|                           |                       |
|---------------------------|-----------------------|
| Office use only           | Date _____ by _____   |
| Total pmt/ck amt _____    | ck # _____            |
| Hooper youth instruction  | \$ _____              |
| Fac/Staff Markup (+25%)   | \$ _____              |
| Union Membership          | \$ _____              |
| Total paid for this youth | \$ _____              |
| Date into Dbase _____     | by _____              |
| POS _____                 | Date of Deposit _____ |
| Additional comments:      |                       |

**Fees:**

Introductory 6 month \$ \_\_\_\_\_  
 Union membership (\$30) (may only be used 1st year)

OR

Annual Union Membership (\$50) - complete form

Session # \_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_

Family special \$ \_\_\_\_\_

Deduct \$50 off one form if 3 or more sessions are registered from the same family at the same time.

Late registration fee (\$20) \$ \_\_\_\_\_  
Within one week of class start

Transfer fee (\$10) \$ \_\_\_\_\_  
To switch classes or cancel

Late cancellation fee (\$25) \$ \_\_\_\_\_  
Within one week of class start

Youth Scholarship Fund Donation \$ \_\_\_\_\_  
(complete separate form)

Total \_\_\_\_\_

**Youth T-shirt**

(One free per 2009 participant)

Circle Adult sizes: S M L

Youth sizes: S M L

**Payment & Mailing Info**

Check enclosed made payable to the Wisconsin Union with the Union membership # on the check to: Hooper Youth Program Registration  
800 Langdon St., Madison, WI 53706

Credit Card  MC  Visa

Card Number \_\_\_\_\_ Exp date \_\_\_\_\_

Cardholder (please print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Hoofer Youth Program release of liability & consent for medical treatment

Youth's Name: Last \_\_\_\_\_ First \_\_\_\_\_  
Please read this document completely before signing. Its purpose is to inform participants of possible risks involved and to release the University from any liability resulting from your participation in the activity described below.

## RELEASE OF LIABILITY AND PARTICIPATION AGREEMENT

**Description:** The Wisconsin Hoofers offers a variety of programs for youth instruction. Programs involve strenuous physical activity in such hazardous action sports as sailing, windsurfing, scuba diving, kayaking, canoeing, and horseback riding. These activities pose many risks, which include, but are not limited to, physical injury, disability, disfigurement and even death. Specific risks include drowning, hypothermia, head and neck injuries, broken bones, lacerations, contusions, skin punctures, contact wounds, abrasions and other causes and results inherent in these activities.

**Health/Medical:** We acknowledge that our son/daughter is physically able to participate in such activities. We further understand that the University provides accident insurance up to \$5,000 per student, but medical costs which are not covered by the program remains the responsibility of the parent(s) or guardian(s). Coverage is limited to accidental injuries only, not illness.

**Release of Liability:** In consideration for my son/daughter's participation in Hooper Youth Instruction programs, I/we hereby release and discharge, indemnify and hold harmless, the Board of Regents of the University of Wisconsin System, its officers, employees and agents, Wisconsin Hoofers, and Memorial Union Building Association and its respective officers, employees and agents, from any liability for damage to or loss of personal property, sickness and injury from whatever source, legal entanglements, imprisonment, death, loss of money, etc., which might occur while participating in these activities. We understand the potential hazards of participation in such activities. We understand that participation is voluntary and, for ourselves and our child, we affirm that we freely choose to do so.

**Conduct:** We understand that the participant may be dropped from the program with no registration refunds if his/her behavior is deemed unacceptable or uncontrollable. We agree to assume the obligations for the expenses of repair and/or replacement of program equipment that is attributable to our child's reckless or irresponsible behavior. We agree to make an appointment for a parent-instructor conference, if required.

I have read and do understand the contents of this release form and agree to the terms and conditions.

\_\_\_\_\_ X \_\_\_\_\_  
Parent/guardian's name Signature Date

## CONSENT FOR MEDICAL TREATMENT

If your child/ward will be under the age of 18 while attending our program, it is our policy to secure your consent for medical treatment. By signing below you are giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.

X \_\_\_\_\_  
**Signature** of Parent or Guardian Date

## CONSENT FOR MEDICAL ADMINISTRATION

If your child/ward will be under the age of 18 while at the University of Wisconsin-Madison, it is UW policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device can be self-administered or be administered by designated staff. You must also complete and sign the following statement:

- \_\_\_ No medication will be brought.  
\_\_\_ I want the medication or medical devices self-administered. (Age 14 and above only.)  
\_\_\_ I want the medication or medical device administered by the designated staff person. However, a limited amount of medication for life threatening conditions may be carried by my child/ward. (i.e. bee sting kits, inhalers)

Comments: \_\_\_\_\_

**All medication must be in a medicine bottle and clearly marked as to the name of the medication, amount to be taken and how, the time to be taken, and any other special instructions.**

X \_\_\_\_\_  
**Signature of Parent or Guardian** Date

## Photo Release

I grant permission to use photographs of my minor child in print or online materials designed for news, informational or educational purposes related to the University of Wisconsin-Madison.

Signature of Parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

# Hoofer Youth Health History Questionnaire

Participant \_\_\_\_\_

Last

First

Middle Initial

Home address \_\_\_\_\_

Street

City

State

ZIP

Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone (\_\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_\_) \_\_\_\_\_

Address if different than above \_\_\_\_\_

In case of emergency (and you are unable to be reached) contact \_\_\_\_\_

Relationship \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Name of physician \_\_\_\_\_ Hospital \_\_\_\_\_ Phone \_\_\_\_\_

Name of insurance company: \_\_\_\_\_ Policy# \_\_\_\_\_

Class/Event \_\_\_\_\_

Dates \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_ F \_\_\_ M

Height \_\_\_\_\_ Weight \_\_\_\_\_

Immunization Record:

MMR (measles, mumps, rubella)

Dose 1 \_\_\_/\_\_\_/\_\_\_

Dose 2 \_\_\_/\_\_\_/\_\_\_

Tetanus-Diphtheria Initial series \_\_\_/\_\_\_/\_\_\_

Last Booster \_\_\_/\_\_\_/\_\_\_

Have you ever had major surgery or been hospitalized? \_\_\_ Yes \_\_\_ No

Please explain any significant operations, accidents, or illnesses, and last medical attention and reason:

\_\_\_\_\_

\_\_\_\_\_

Does the participant have any physical conditions requiring special considerations? Explain.

\_\_\_\_\_

A physical examination within 24 months of the camp/event is recommended. Date of participant's last physical examination. \_\_\_/\_\_\_/\_\_\_

Are you taking any medication regularly?

\_\_\_ Yes \_\_\_ No

If yes, identify: \_\_\_\_\_

\_\_\_\_\_

(Consent for Medication Administration must be signed on reverse.)

Has participant had or is experiencing:

SERIOUS

SOME

NONE

|                             |                          |                          |                          |
|-----------------------------|--------------------------|--------------------------|--------------------------|
| Allergies                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Disorder           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Colitis                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Seizures/Blackouts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disease               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hernia                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Injury/Surgery        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Disease              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Menstrual Difficulties      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental/Emotional Problems   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck/Back Pain/Injury       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Does participant have allergic reactions to:

SERIOUS

SOME

NONE

|                          |                          |                          |                     |
|--------------------------|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other Antibiotics   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other Medications   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insect bites/stings |