



(FORM # 1)  
**2012 Washington Business Week  
 Summer Programs  
 Student Medical Information Form  
 and Photo Release**

**SECTION I. ATTENDANCE**

I will be attending a Business Week Program at:     WESTERN     GONZAGA     CENTRAL     PACIFIC LUTHERAN

**SECTION II. GENERAL INFORMATION**

New/Corrected Address

**EMAIL for all BW COMMUNICATIONS:**  
 \_\_\_\_\_

1. Student First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_ Birthdate \_\_\_\_\_

2. Ethnicity (for statistical purposes only):     African American / Black     Asian     Pacific Islander     Caucasian / White  
 American Indian     Native Alaskan/Aleutian     Hispanic / Latino     Other \_\_\_\_\_

3. Home Phone (\_\_\_\_\_) \_\_\_\_\_ Student Cell (\_\_\_\_\_) \_\_\_\_\_ Student Email \_\_\_\_\_

4. Parent/Guardian Name \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_ Parent Cell (\_\_\_\_\_) \_\_\_\_\_ Parent Email \_\_\_\_\_

5. Please give the name and phone number of **two** people to call who will assume responsibility for your son or daughter in case of an emergency during their time at Washington Business Week **if we are unable to reach a parent or guardian.**

Name #1 \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_

Name #2 \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_

**SECTION III. MEDICAL INFORMATION**

1. Are you taking any prescription medications?     YES     NO    Please review our medication policy at [www.wbw.org](http://www.wbw.org).

	Medication	Medication	Medication	Medication
Name:				
Dose:				
Purpose:				
Controlled?				

2. Do you have any allergic reaction to any of the following:     Insects     Food (describe)     Penicillin     Plants  
 Other/please describe \_\_\_\_\_

3. Do you have any specific health problems or special needs that would affect your ability to participate in an active program?  
 YES (please specify)     NO

Do you need any special accommodations to actively participate in the program?     YES (please specify)     NO

\_\_\_\_\_

4. Do you have a history of:     ADD/ADHD     Asthma     Autism/Aspergers     Convulsions or Epilepsy     Depression  
 Diabetes     Heart Trouble     Hearing Impairment     Physical Impairment     Visual Impairment  
 Other \_\_\_\_\_

5. Are you currently limited in physical activity?     YES     NO  
 If yes, please specify: \_\_\_\_\_

