

**2008 STUDENT LEADERS RETREAT  
AUGUST 20-22, 2008**

**REGISTRATION FORM – *FOR THOSE STUDENTS WHO HAVE BEEN SELECTED***

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*Please print/type clearly*

Name: \_\_\_\_\_

Fall Campus Address: \_\_\_\_\_

Fall Campus Telephone: \_\_\_\_\_

E-mail: \_\_\_\_\_ *(please note that most communication will be via e-mail)*

Your name as you would like it to appear on your nametag: \_\_\_\_\_

Primary Student Organization: \_\_\_\_\_

Office/Position held within the above organization: \_\_\_\_\_

T-Shirt Size: (circle one)    S            M            L            XL            XXL

In the event of an emergency, whom should we contact?

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

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

***Payment Information:***

\_\_\_\_\_ My \$20 registration fee is enclosed. (check made payable to Student Leaders Retreat)

**OR**

\_\_\_\_\_ Please bill my student organization \_\_\_\_\_.

(If you choose this option, an invoice will be e-mailed to you.)

**Please initial the following statements and sign below signifying you agree to abide by the expectations for the conference.**

\_\_\_\_\_ I understand that as a participant at the Student Leaders Retreat, I am expected to abide by all Purdue University regulations and policies. I further understand that I will be held accountable to these policies.

\_\_\_\_\_ I agree to be 100% involved in all activities and to arrive on time to all scheduled events from 1:30 p.m. on Wednesday until 1:30 p.m. on Friday.

\_\_\_\_\_ I agree to come to the retreat with an open mind, willing to learn and share, while respecting individual differences and differing opinions.

\_\_\_\_\_ My medical information form is enclosed (see form below).

\_\_\_\_\_  
**Signature** (Your signature indicates you agree to the statements above.)

\_\_\_\_\_  
**Date**

**Please return your forms and check by Friday, August 1 to:**

Carol E. Ben-Davies / Student Leaders Retreat  
475 Stadium Mall Drive

Schleman Hall of Student Services, Room 250  
West Lafayette, IN 47907-2050

Phone: 765.494.1231 / Fax: 765.496.1902 / TTY: 765.494.1247

Name \_\_\_\_\_

**Medical Information Form**

Please complete sections I, II and III. If you answer “Yes” to any questions in Section II, make sure to give details in the space available. If you need more space, attach another sheet.

**A student will not be rejected due to either his/her physical or emotional condition unless it is of such a serious nature as to prevent successful participation in the activity.**

A health record is **confidential** and accessible only to health personnel and the staff of the Office of the Dean of Students. Information regarding an applicant’s health, however, is important in anticipating and dealing with health problems, which may arise during SLR.

Should you develop significant health problems between the time you have completed this form and commencement of the activity, which may influence your participation in the program, it is your responsibility to notify the Office of the Dean of Students at Purdue University. A medical report should accompany this notification.

**I. General Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Permanent Address \_\_\_\_\_  
 Street City State Zip Code

Health Insurance \_\_\_\_\_

**II. Personal History (to be completed by the student)**

Have you ever had or do you now have (check yes or no):

	Yes	No		Yes	No
Chicken Pox			Chronic Skin Problems		
Hepatitis			Epilepsy		
Infectious Mononucleosis			Fainting Spells		
Tuberculosis or contact with Tuberculosis			Migraine Headaches		
Malaria			Endocrine Disorder(s)		
Heart Problems			Diabetes Mellitus		
High Blood Pressure			Anemia		
Irregular or Rapid Heart Beat			Anxiety Reactions		
Pain or Pressure in the Chest			Allergies to Medications		
Asthma			Operations(s)		
Significant Allergic Reaction(s)			Serious Accident(s)		
Chronic or Recurrent Gastrointestinal Problems			Physical Handicap(s) (please elaborate)		
Kidney Problems			Are you currently taking any medications (list)		
Hernia			Other		

Give details of those items checked “Yes” using the space below, adding additional sheets if necessary. Indicate problem, diagnosis if known, and whether recovery has been complete or if still under treatment.

**III. Current Medical History**

1. Have you been in good health during the past 12 months? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Do you have any significant chronic medical conditions requiring on-going medical supervision and treatment, or have you had in the past any significant condition which is currently in remission? (Ex. diabetes, heart problems, chronic or recurrent gastrointestinal disorder, seizure disorder, treatment for cancer, bleeding disorder, etc.) Yes \_\_\_\_\_ No \_\_\_\_\_
3. Are you currently receiving, or have you received in the past two years, counseling for any emotional problem, drug addiction, alcoholism, psychiatric condition or eating disorder? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Do you have any dietary restrictions or food allergies? Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes, please specify:  

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**I certify that all responses made on this Medical Information Form are true and accurate, and I will notify the Office of the Dean of Students hereafter of any relevant changes in my health that occur prior to the start of the trip.**

**Signature of Applicant** \_\_\_\_\_ **Date** \_\_\_\_\_