Oglebay Institute

Inspiring the Imagination

OGLEBAY INSTITUTE ADULT INFORMATION FORM

Please return to: Stifel Fine Arts Center, 1330 National Rd. Wheeling, WV 26003

Name: _____ Age:_____ _Male □ Female

Home Address:_____ Home Phone:_____

City, State & Zip: _____

Email Address_____

Work Address: _____ City, State & Zip _____

Work Phone: _____ Cell Phone: _____

EMERGENCY INFORMATION

Emergency Contact Name: _____ Phone:_____

Address: _____ Relationship _____

Medical Insurance Provider: _____Policy/Group #: _____

Physician/Medical Care Provider: _____Phone: _____

Please indicate emergency facility choice: ___Wheeling Hospital ___Ohio Valley Medical Center

HEALTH INFORMATION

Allergies (including medication): _____

Special Disabilities (if any): _____

Dietary Restrictions: _____

Activity Restrictions: _____

Other Needs (medical conditions, medications, etc.): _____

PHOTOGRAPH AND PUBLICITY RELEASE

I give my consent to Oglebay Institute to use my name, likeness, image, voice, and/or appearance to promote its, its fiscal agent, and/or their activities in uses which may include, but are not limited to illustrations, bulletins, exhibitions, videotapes, reprints, reproductions, publications, advertisements, and any promotional or educational materials in any medium not known or later developed. I agree that Oglebay Institute has complete ownership of such pictures, etc., including the entire copyright, and may use them for any purpose consistent with Oglebay Institute's missions.

_____*initial*

By completing and signing this form, I hereby give my consent to Oglebay Institute for the following: Obtain emergency medical care and administer minor first aid procedures. I hereby release and hold harmless, Oglebay Institute, its employees and its agents from any and all liability for any and all harm arising as a result of participation.

Signature: _____ Date: _____