



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 Other – Please Specify: _____

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: _____