

WISCONSIN CONFERENCE
UNITED METHODIST WOMEN
SEMINAR PROGRAM 2017

Part A: REGISTRATION FORM

Full Name (print) _____
(as it appears on your passport or photo ID)

Date of Birth _____

Age _____ Gender _____ Height _____ Weight _____

Address: _____

City: _____ Zip: _____

Phone: _____ Cell Phone: _____

Primary Insurance Co: _____

Secondary Insurance Co: _____

(attach copy of front and back of health cards)

In case of emergency please notify the person below:

Name: _____ Relationship: _____

Phone: _____ Cell: _____

Part B: Health History (use back of form if needed.)

LIST ANY ALLERGIES, MEDICAL CONDITIONS and MEDICATIONS: