Stay Strong, Stay Healthy

Participant Enrollment

Name: ______________________________

Best phone number: ______________ Email: ______________

Age and year of birth: ______________ Gender: ______________

In case of emergency, please call (please list two contacts):

Name: ______________________________

Relation: ______________ Phone number: ______________

Name: ______________________________

Relation: ______________ Phone number: ______________

Previous SSSH participant? ❑ Yes or ❑ No

Follow-up survey for first time participants:

If you are a first time-participant, are you willing to complete a follow-up survey?
❑ Yes or ❑ No

If yes, may we send the survey via email? ❑ Yes or ❑ No, please send via mail

Street Address: ______________________________

City: ______________ State: __________ ZIP: __________

At ______________________, we want to make sure we are presenting our programs to a wide range of participants. This information is voluntary and confidential, and will be used to identify our audiences in general.

Race
- ❑ American Indian/ Alaskan Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White
- ❑ Two or more races/ Other
- ❑ Unknown

Hispanic
❑ Yes ❑ No

Veteran status
- ❑ Nonveteran
- ❑ Veteran
  - ❍ Vietnam Veteran
  - ❍ Other

Disabled
❑ Yes ❑ No

Are you seeking State of Kansas Health Quest credits for this course? If yes, please provide your legal name employee ID number and birth date below. (This is a Letter followed by 10 numbers.)

I need to tell you…
Here's where you can put any pertinent health conditions that you think the instructor needs to know.

Returning participant initial if all responses are the same

_____ ***Date*** _________

For instructor use. Valid for one year.

--- Below is for instructor use only ---

Program site:

County:

Start date:

Extension
University of Missouri
an equal opportunity/ADA institution

K·STATE
Research and Extension