



Parent/Guardian Consent & Contact Form 2014-2015

Print Child's Name: _____

Parent's Name: _____ Phone # _____

Address: _____

E-mail Address: _____

IF THE PARTICIPANT IS UNDER 18 YEARS OF AGE, THE CUSTODIAL PARENT AND/OR LEGAL GUARDIAN MUST SIGN AND DATE THE FOLLOWING STATEMENTS OF CONSENT. PLEASE INITIAL NEXT TO EACH STATEMENT BELOW.

Parent/Guardian Consent:

_____ I/we give our son/daughter permission to participate in the spectrUM program at the University of Montana, Missoula, Montana.

_____ I/we agree to assume all risks involved in participation in the spectrUM program. In consideration for the University of Montana's effort in providing the program, I/we further agree to hold the University, its employees and other said agents harmless from any and all liability for injuries that result from my son's/daughter's participation in the program.

_____ I/we consent to the provision of any necessary emergency treatment to my son/daughter during the program by spectrUM staff, local physicians, and/or hospital personnel, in the unlikely event of an emergency.

_____ I/we agree to allow spectrUM to use photos and or video of my son/daughter engaged in scientific explorations for promotional materials, and grant purposes.

_____ I/we understand that violent or unsafe behavior is cause for dismissal from the spectrUM workshop.

Parent/Guardian Name (Printed)

Parent/Guardian Signature

Date

Relationship to student



Health History Form & Permission to Receive First Aid 2014-2015

Name: _____

Date of Birth: ____/____/____

We require full disclosure of your child's current health, and health care provider information. The information that you provide may assist people in the unlikely event of an accident while participating in the spectrUM program. Therefore, before you fill out this form, please read it carefully. Full and accurate completion of all sections is very important.

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PLEASE LIST ALL INFORMATION REGARDING THE FOLLOWING:

All known allergies: _____
(E.g. peanuts, bees)

Disabilities: _____

Heart Conditions: _____ Phobias/Fears: _____

Past Injuries/Illnesses/Seizures and Dates: _____

Past Operations and Dates: _____

Current Medications: _____

Contacts/Glasses: _____

Other Important Information, Not Previously Mentioned: _____

Primary Doctor's Name: _____ Phone: _____

Doctor's Address: _____

Insurance Policy/Provider: _____ Group Number: _____

Blood Type: _____ Height: _____ Weight: _____
(if known)

PERMISSION TO RECEIVE FIRST AID & TO SECURE MEDICAL HELP

My child is sufficiently fit to participate in this program. The health history information I provided is accurate, complete, and true to the best of my knowledge. I agree to notify the program facilitators of any changes to my child's health and fitness, which may occur before or during the program. Should my child become ill or injured, I give my permission for any representatives of the spectrUM Discovery Area or the University of Montana to render first aid and seek emergency medical or rescue services, as they see fit and at my expense.

Parent/Guardian Name (Printed) (if student is under the age of 18)

Parent/Guardian Signature (if student is under the age of 18)

Date