

spectrUM Discovery Area 2020
Parent/Guardian Consent & Contact Form

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 child permission to participate in the spectrUM workshop at the University of Montana, Missoula, Montana.

_____ I/we agree to assume all risks involved in participation in the spectrUM workshop. 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 child's participation in the program.

_____ I/we consent to the provision of any necessary emergency treatment to my child 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 child 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.

_____ I/we give our child permission to ride the Mountain Line bus for field trips, as scheduled.

Parent/Guardian Name (Printed)

Parent/Guardian Signature

Date

Relationship to student

spectrUM Discovery Area 2020

Health History Form & Permission to Receive First Aid

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.

Name: _____

Date of Birth: ____/____/____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

PEOPLE AUTHORIZED TO PICK UP MY CHILD AFTER CAMP:

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

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 Medical Information, Not Previously Mentioned: _____

Primary Doctor's Name: _____ Phone: _____

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 program 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