spectrUM Discovery Area 2017-2018

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 son/daughter 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 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

spectrUM Discovery Area 2017-2018

Health History Form & Permission to Receive First Aid

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 Medical 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 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