I grant permission for (print participant’s name) _____________________________ to participate in all educational and social activities of the following MSU program or activity:

Program name: ________________________________________________

Program dates: ___________Sep 28 - Nov 23_____________________

MSU unit/department: ______CSE & WIE K-12 Outreach_________________

I understand that sessions may entail field trips and/or campus facility tours. I also understand that participants may engage in athletic or other recreational activities that have special risks.

I have read the session descriptions and approve of my child’s selections. I accept any risks associated with the assigned sessions and selected recreational activities.

I understand that my child has a role to play as regards their safety and security. I will speak with my child about the need to honor safety rules and to behave responsibly.

(Please print):

________________________________________________________________

(Parent or legal guardian)
Signature: ___________________________ Date: _____________________
MEDICAL TREATMENT AUTHORIZATION FOR MICHIGAN STATE UNIVERSITY

Your child will be involved in a Michigan State University program on the above date(s). This form must be completed and signed by a parent or guardian to give a medical facility permission to treat the participant for minor injuries or medical problems. In the event of serious injury or illness, the parent or person designated will be contacted. Treatment will proceed before contacting the parent or person designated only if the situation is urgent and does not permit delay.

Participant's full legal name: ____________________________________________
Last   First   M.I.
Mailing Address: ________________________________________________________

Birth date: ______________________

Parent phone: day (   ) ________ evening: (   ) ____________

Primary care physician's name: ________________________

Physician's phone: _________________________________

Physician's address: ________________________________

HEALTH INSURANCE INFORMATION (If the participant does not have health insurance, please indicate 'NONE'):

Policy holder's name and relationship to participant ________________________________________________________

Policy holder's address: ______________________________________________________________________________

Please attach a photocopy of both sides of your insurance card OR complete the information requested below.

Insurance company name and address: _________________________________

Insurance company phone number: (____) ______________________________

All policy numbers (please identify): ______________________________________

If you have HMO insurance, please list the emergency treatment authorization phone number: (____) _________________

Employer's name and address: ____________________________________________

Business phone (____) ______________________________

INFORMATION NEEDED ABOUT PARTICIPANT: Please check yes or no. If yes, explain below or on another sheet if you need more room.

YES  NO

Does the participant have any chronic health problem or illness? _______ ________

Does he or she have any acute illness now? _______ ________

Has the person been treated recently for some medical problem? _______ ________

Does he or she have any allergies? _______ ________

Does he or she have any allergies to medication or local anesthetics? _______ ________

Date of his or her last tetanus shot ________________________

List any medications he or she is now taking for treatment of any medical problem. ____________________________________________

OFFICIAL AUTHORIZATION FOLLOWS:

I (parent or legal guardian), __________________________________, recognize that while attending this program, medical treatment on an emergency basis may be necessary for my child, and I further recognize that the program director may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the circumstances and to assume the expenses of such care. I also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature of Parent/Guardian or of participant aged 18 and up ______________________ Date ______________________
MICHIGAN STATE UNIVERSITY MEDIA RELEASE FORM

Participants in MSU-sponsored programs and activities may be photographed and videotaped for use in MSU promotional and educational materials. The participants are not identified by name in the materials.

I authorize MSU to record the image and voice of the subject named below and I give MSU, and all those acting with MSU’s approval, all rights to use these images and voice recordings. I understand that such images and/or recordings may be used for educational and promotional purposes. This authority extends to all conventional and electronic media, including the Internet and any future media, and to any printed material.

I understand and agree that these images and recordings may be duplicated, distributed with or without charge, and/or altered without compensation or liability, in perpetuity.

Print subject’s name: ____________________________________________

Signature of Parent/Guardian of minor participant or of participant aged 18 and up:

_________________________________________________________ Date: ____________

_________________________________________________________ Date: ____________