



SCIENCE, TECHNOLOGY, ENGINEERING & MATH

Summer Adventure



the INSTITUTE FOR ADVANCED LEARNING AND RESEARCH

2024 Health History And Authorization Form

INSTRUCTIONS: Please provide detailed health information for determining appropriate supervision, support, and accommodations for the STEM Summer Adventure (SSA) topic listed. **A parent or guardian must sign.** If the participant is a person with disability and desires any assistive devices, services or other accommodations to participate in this activity, please contact Dana Silicki at (434) 766-6729 at least 21 days prior to the event start date to discuss accommodations.

PLEASE PRINT ALL INFORMATION.

Office Use Only

Unit: _____

Date Received: _____

List each SSA Topic in which student is registered:

1. _____
Dates of Event: _____ Location: _____
2. _____
Dates of Event: _____ Location: _____
3. _____
Dates of Event: _____ Location: _____

Participant Identification

Name: _____
Last First Middle Initial

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Home Email: _____

Cell Phone: () _____

Age: _____ Date of Birth: _____ Female: Male:

Parent/Guardian Identification

Father's Name: (or Guardian) _____

Work Phone: () _____ Email: _____

Cell Phone: () _____

Mother's Name: (or Guardian) _____

Work Phone: () _____ Email: _____

Cell Phone: () _____

Who has legal custody of the participant? _____

Please note: If both parents have legal custody, both parents are required to sign all paperwork.

Physician/Insurance Information

Family Physician Name: _____ Phone: () _____

Dentist/Orthodontist Name: _____ Phone: () _____

Do you carry family medical/hospital insurance? Yes No (If Yes, please provide photocopy of insurance card)

Carrier: _____ Policy/Group #: _____

Emergency Contact Information

Emergency Contact (outside of home): _____

Emergency contact phone number: _____

Relationship to student: _____ Phone: _____

Participant Health and Medical History (Questions 1-9 must be completed.)

1. Does the participant have any known allergies? (Including: food, medicine, plants, animals, insects, other)
Yes No If YES, please explain: _____
2. Does the participant require a special diet (including dietary allergies, vegetarian, dietary restrictions, etc.)?
Yes No If YES, please explain: _____
3. Has the participant ever experienced (or had special needs in) any of the following? [Check all that apply]
 Asthma Bleeding disorders Attention disorders (ADHD) Eating disorders Seizures/Convulsions
 Diabetes Wears contacts Autism Behavioral Fainting spells Other _____
4. Is the participant experiencing any current health problems, under medical care, receiving mental or behavioral services, or currently taking/prescribed medication?
Yes No If YES, please explain: _____
5. Has the participant undergone surgery, or experienced any injury, illness, allergy, or change in health status any time during the last year that limits/restricts participation in a program or activity?
Yes No If YES, please explain: _____
6. Does the participant have a need for, carry, or use any emergency or rescue medications such as epinephrine, albuterol, or rescue inhalers?
Yes No If YES, please identify and explain: _____
7. Is there additional information that essential staff should know (including behavioral/ physical/ emotional disabilities, medication instructions, and/or special restrictions) in order to identify and provide appropriate supervision, support, and accommodations for the participant?
Yes No If YES, please explain: _____
8. Is the participant current/up-to-date on all legally required immunizations at the time of completion of this document?
Yes No If NO, please explain: _____
9. Via signature below, the parent/legal guardian completing, signing, and submitting this document confirms that the participant will be up-to-date on all legally required immunizations throughout the time of participation in the 2024 SSA program(s).
Yes No If NO, please explain: _____

Medical Approval/Emergency Authorization

(Please read parts 1 through 3. If the participant is under 18, parent(s)/guardian(s) must sign in the space provided. If you are over the age of 18, please sign yourself. If you cannot sign this due to religious reasons, you must contact the Institute for Advanced Learning and Research (IALR) to obtain a legal waiver that must be signed. **If this section is not signed, participation in the SSA program will not be allowed.** You must contact IALR in writing if there is a change in health status after submitting this form.

1. I give my permission for the participant named on this form to attend the designated SSA program. He/She has permission to participate in all scheduled activities/fieldtrips under the supervision of instructors, subject to limitations noted above.
2. I hereby give permission to any health care providers selected by the Program Coordinator, Instructor or assigned designee, to perform emergency diagnostic, therapeutic, and operative procedures as may be deemed necessary for the participant, including without limitation X-rays and tests as medically necessary. I understand that all attempts will be made to notify parents/guardians of any serious injury or illness to their child. If I cannot be reached in an emergency, I hereby give permission to the selected health care providers to transport, hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for me/or the participant named on this form. This form may be photocopied for use outside of the event/activity location.
3. I hereby agree to pay for, or arrange payment for, any expenses related to medical treatment the participant may be required to undergo as a result of or in connection with his/her/my participation in any SSA programs or activities. I further agree to indemnify SSA, the Institute for Advance Learning and Research, and/or all of their agents and designees against any claims, suits, or demands for payment that may be asserted in connection with any injuries the participant suffers or medical treatment that the participant may incur in connection with his/her/my participation in any SSA programs or activities.

Signed: X Date: _____
(Parent/Legal Guardian #1 or participant over 18 years old)

Signed: X Date: _____
(Parent/Legal Guardian #2)

Signed: X Date: _____
(Participant under 18 years old)

Release Authorization

I give permission for the following person(s) to pick my child up during SSA programming (list your name and **ALL** others who have permission to pick up your child, including yourself).

*Note: Participants will not be permitted to leave with anyone other than those designated below and **Photo ID will be REQUIRED.***

*For the safety of participants, an authorized adult must **come inside the facility** to sign in and sign out the participant daily.*

Name: _____	Relationship to SSA Student: _____
Name: _____	Relationship to SSA Student: _____
Name: _____	Relationship to SSA Student: _____
Name: _____	Relationship to SSA Student: _____
Name: _____	Relationship to SSA Student: _____