

# AUTHORIZATION FOR PURPOSES OF PROVIDING MEDICAL TREATMENT

## ROCKETS FOR SCHOOLS GREAT LAKES SPACE PORT EDUCATION FOUNDATION, INC. Sheboygan, Wisconsin

**NOTE: FORM MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN BEFORE YOUTH CAN PARTICIPATE IN ROCKETS FOR SCHOOLS ACTIVITIES**

I, \_\_\_\_\_, hereby grant the below named participant, permission to attend Great Lakes Space Port Education Foundation, Inc./ Rockets for Schools events held from May 11, 2012 thru May 12, 2012.

Furthermore, in the case of an accident, I will not hold Great Lakes Space Port Education Foundation, Inc. / Rockets for Schools, the Sheboygan Area School District, and Tripoli Rocket Association, The City of Sheboygan or other participating organizations responsible for damages incurred. I do hereby authorize Great Lakes Space Port Education Foundation, Inc. /Rockets for Schools, the Sheboygan Area School District, Tripoli Rocket Association and the City of Sheboygan or other participating agencies to incur medical costs necessary to provide treatment for said child, for which we shall be fully responsible. We 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.

I understand that participants are sometimes photographed and/or video taped for use in R4S promotional and education materials and I am giving my permission to do this. **CHECK ONE: Yes  No**

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
Date

### Please Print Clearly

Rockets for Schools Participant Name _____	Birth date _____	
Address _____	Physician _____	
Address _____	Day Phone _____	
City/State/Zip _____	Evening Phone _____	
Participant's School _____		
<b>Who to reach in case of an emergency?</b>		
Name _____	Relationship _____	Phone _____
Name _____	Relationship _____	Phone _____

### INFORMATION NEEDED ABOUT PARTICIPANT: If yes, Indicate Below

Is there any chronic problem or illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes _____
Is there any acute illness now present?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes _____
Has the person been treated recently for any medical problem?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes _____
List any medications now being taken for treatment of any medical problem	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes _____
Are there any allergies to medication or local anesthetics?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes _____
Are there any allergies?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes _____
DATE of last Tetanus shot _____			

### INSURANCE INFORMATION: Policyholder's Name and Relationship to Patient

Policy Holder's Address _____
Name and Address of Insurance Company _____
Name and Address of Employer _____
Business Phone Number _____
ALL Policy numbers (Please Identify) _____