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			

Who to reach in case of an emergency?

Name		Relationship		Phone	
Name		Relationship		Phone	

INFORMATION NEEDED ABOUT PARTICIPANT: If yes, Indicate Below

Is there any chronic problem or illness?	Yes ☐	No ☐	If yes		
Is there any acute illness now present?	Yes ☐	No ☐	If yes		
Has the person been treated recently for any medical problem?	Yes ☐	No ☐	If yes		
List any medications now being taken for treatment of any medical problem	Yes ☐	No ☐	If yes		
Are there any allergies to medication or local anesthetics?	Yes ☐	No ☐	If yes		
Are there any allergies?	Yes ☐	No ☐	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) _____