

MUW SCIENCE ENRICHMENT PROGRAM FIELD TRIP WORKSHOP REGISTRATION PACKET

To complete this packet, you must turn in completed forms for:

- 1.) One teacher/adult form for yourself and any adult chaperones (first 2 pages of packet)
- 2.) One youth form per student participant (third and fourth pages of packet)

Please indicate the **date(s)** and **title(s)** of the workshop(s) to which you are applying in order of preference:

1. _____
2. _____
3. _____

Applicant Name: _____
Last First Middle Initial

Mailing Address: _____
Number and Street, Box or Route City, State, Zip Code

Telephone (best to reach you): _____

E-mail Address (best one): _____

Gender: Male Female

Adult Race/Ethnicity: African American/Black Asian/Pacific Islander
 Caucasian/White Hispanic Native American Other

School Where You Teach: _____

School Description: _____
(student body, funding, demographics, etc.)

City and State: _____

District: _____ Years of Teaching Experience: _____

Grade(s) Taught: _____ Subject(s) Taught: _____

Mississippi University for Women does not discriminate on the basis of race, color, religion, gender, age, sexual orientation, national origin, disability, or veteran status in admission, in treatment, in employment, or in access to its programs and activities.

In case of emergency, please contact:

Name _____ Relation _____

Phone 1. _____ 2. _____

Address _____

City _____ State _____ Zip _____

MEDICAL HISTORY

Please list any health conditions (illness, allergies, limitations, or medications) or special circumstances of which we should be aware that might help us in better preparing for your participation. _____

Insurance Carrier _____

Policy # _____ Group # _____

Address of carrier _____

I have a fear of water: Yes No

My photo may be used by the SEP for future promotional materials: Yes No

It is expressly understood and agreed that the Mississippi University for Women shall not be responsible or legally liable for any losses of personal property or for any bodily injuries, or the results thereof, incurred and suffered by the participant in connection with any activities of programs.

Print Name _____

Signature _____ Date _____

Registration forms will be accepted until sessions are full. Slots will fill on a first-come-first-served basis. To check capacity status, log on to our website at: http://www.muw.edu/sci_math/sep

Please e-mail inquiries to Kenny Langley: klangley@as.muw.edu or call 662.329.7379

Mail completed forms to:

*Attn: Kenny Langley
SEP Field Trips
1100 College St., MUW-100
Columbus, MS 39701*

**MUW Science Enrichment Program (SEP)
YOUTH MEDICAL & WAIVER FORM**

Supervising Teacher: _____

Student Participant Name _____

D.O.B. _____ Age _____ Gender: M F

Race/Ethnicity: African American/Black Asian/Pacific Islander
 Caucasian/White Hispanic Native American Other

Name of School _____ Current Grade _____

Parent/Guardian Name _____

Relation _____

Address _____ City _____

State _____ Zip _____

Phone (Day) _____ Phone (Night) _____

E-mail _____

If Parent/Guardian is unavailable in an emergency, please contact:

Name _____ Relation _____

Phone _____ Address _____

City _____ State _____ Zip _____

STUDENT HEALTH & ALLERGY HISTORY (please check any and all that apply)

Ear Problems Hay Fever Poison Ivy Bleeding Disorder

Heart Disease/Defect Diabetes Insect Sting Asthma

Seizures/Convulsions Inhaler Penicillin Carry Sting Kit

Other conditions, illness, allergies, limitations, or medications: _____

Restricted Activities: _____

Reason: _____

Name of Family Physician _____ Phone # _____

Do you have Family Medical/Hospital Insurance? Yes No

If yes; name of carrier _____

Policy # _____ Group # _____

Address of carrier _____

Does your child have a fear of water? Yes No

My child's photo may be used by the SEP for future promotional materials: Yes No

The health history in this form is correct and complete and the person herein described has permission to engage in all prescribed activities except those listed above. I hereby give permission to the physician selected by the Program Coordinator to order x-rays, routine tests, and treatment for the health of my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Project Coordinator to hospitalize, secure proper treatment for, and order injection, and or anesthesia, and or surgery for my child as named above and I accept financial responsibility for all treatment.

It is expressly understood and agreed that the Mississippi University for Women shall not be responsible or legally liable for any losses of personal property or for any bodily injuries, or the results thereof, incurred and suffered by the participant in connection with any activities of programs.

Parent/Guardian Print Name _____

Signature _____

Date _____