

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

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

1. _____
2. _____
3. _____

Student Participant Name _____

Supervising Teacher or Adult (workshop #6 Earth and Beyond only) _____

Other student team member (workshop #6 Earth and Beyond only) _____

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

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

Name of School _____ Grade Completed _____

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 _____

**In the section below, unchecked boxes offer implied consent*

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 _____

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
Science Enrichment Program
1100 College St., MUW-100
Columbus, MS 39701*