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 20, 2011 thru May 21, 2011.

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 Co. ____

Name and Address of Employer ____

Business Phone Number ____

All Policy numbers (Please Identify) ____