AUTHORIZATION FOR PURPOSES OF PROVIDING MEDICAL TREATMENT
GREAT LAKES SPACEPORT EDUCATION FOUNDATION, INC. / ROCKETS FOR SCHOOLS
Sheboygan, Wisconsin

I,_____, hereby grant _____ permission to attend Great Lakes Spaceport Education Foundation, Inc./ Rockets for Schools event held from May 12, 2017 thru May 13 2017.

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. **PLEASE CHECK ONE: ☐ YES ☐ NO**

_____ _____/_____/_____
(Parent/Guardian Signature) Date

Please Print Clearly			
Rockets for Schools Participant Name		Birth date	
Address		Physician	
		Address	
Phone		Phone	
Participant's School			
Who to reach in case of an emergency?			
Name	Relationship	Phone	
Name	Relationship	Phone	

INFORMATION NEEDED ABOUT PARTICIPANT:	**YES**	**NO**	**If yes, indicate below** (attach another sheet if needed)
1. Is there any chronic problem or illness?			
2. Is there any acute illness now present?			
3. Has the person been treated recently for any medical problem?			
4. List any medications now being taken for treatment of any medical problem.			
5. Are there any allergies to medication or local anesthetics?			
6. Are there any allergies?			
7. Date of last Tetanus shot:			
INSURANCE INFORMATION:			
8. Policyholder's Name and Relationship to Patient:			
9. Policy Holder's Address:			
10. Name and Address of Insurance Company :			
11. Name and Address of Employer :			
12. Business Phone Number:			
13. ALL Policy numbers: (Please Identify)			

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