

**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, 2023 thru May13, 2023.

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 Rockets for Schools, the local or national news media, and/or non-profit organizations partnering with Rockets For Schools may take photographs, videotape, and/or interview participants of this year's launch for use in promotional and education materials. In signing this form I give my permission for event coordinators to take pictures, digital images, or other recordings of my child and to use these images with compensation on the internet, (e.g. social media), in publications or other printed or electronic materials. I release Rockets for Schools from all future claims or liability arising from the use of any images or recordings.

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

Please Print Clearly

Rockets for Schools Participant Name _____		Birth date _____	
Address _____		Physician _____	
Phone _____		Address _____	
Participant's School _____		Phone _____	

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**