

DISCLOSURE AND AUTHORIZATION FORM 2008

The George Washington University Summer Scholars Pre-College Program

This form does **not** require a physician's signature.

Full legal name of student _____ Date _____
Last, First, Middle

Parent's or guardian's name (if student is under 18) _____ Date _____
Last, First, Middle

Date of birth _____ Age _____ Sex _____

Home address _____

Country _____ Phone _____

Important: Individuals with disabilities, time is of the essence. If you have reason to believe you qualify, according to Federal Statute, for special accommodations for disability, please so indicate by checking the block below. Relevant portions for Section 504 of the Federal Rehabilitation Act of 1973 and the American with Disabilities Act of 1990 require that you identify yourself so that reasonable accommodations can be arranged. If you think you qualify, you must return this form to us no later than 45 days prior to your arrival on campus.

_____ Yes, I have reason to believe that I qualify for special accommodations for disability _____ Not applicable

INSURANCE COVERAGE: You must show proof of health insurance coverage with a U.S. carrier.

Insurance carrier _____ Policy number _____

Carrier address _____ Carrier phone _____

Name of policy holder _____

Please attach a copy of your insurance card. Copy both sides of the card.

MEDICAL HISTORY

Are you receiving any kind of treatment for a medical condition such as asthma, diabetes, a heart condition, high blood pressure, emotional neurological, convulsions, other, etc.? If so, what is the medical condition?

List any medications that you currently take: _____

Please list any known allergies to drugs, food, and insects. Do you require an Epi-Pen? _____

Are there any other concerns, medical or otherwise, you wish to bring to our attention so we can better meet your needs during your stay at The George Washington University? If so, please attach a separate statement.

EMERGENCY CONTACT INFORMATION In the event of an emergency, we will call the student's parent/guardian first. If we cannot reach the parent/guardian, we will call the alternate contact designated below. (Please be sure to inform the Summer Scholars office if any of this information changes during the summer program.)

Parent/guardian _____ Relationship _____

Summer address _____

Summer phone Business/day _() _____ Evenings _() _____ Cell _() _____

Alternate emergency contact _____ Relationship _____

Alternate phone Business/day _() _____ Evenings _() _____ Cell () _____

MORE ON OTHER SIDE

During the summer it may become necessary for a student of The George Washington University Summer Scholars program to receive medical services. The Summer Scholars program will always attempt to notify a student's parent or guardian as early as possible of an illness or injury, keep them informed of the situation, and consult with them about important medical decisions. However, a serious accident or injury may require immediate action and/or treatment without prior notification to the parent or guardian. In order to arrange for you to receive medical services during your participation in the Summer Scholars program, you must read and sign the authorization for treatment below. If you are a student under the age of 18, parental authorization is required.

AUTHORIZATION FOR TREATMENT OF STUDENTS

1. I acknowledge that I have an obligation to provide the requested medical information to the Summer Scholars office prior to my participation in the program and to disclose any injuries, or illnesses of which I am aware by returning this form. I agree to assume all risks and hazards resulting from any undisclosed injuries or illnesses. Further, I authorize the Director, at any time and from time to time during the program, to take such action deemed necessary or desirable for my welfare in the event that I become sick or injured during the Summer Scholars program, including, but not limited to, arranging for necessary medical care or transport for medical care by a licensed health care provider:

- a. When the nature and severity of the illness or injury requires treatment beyond the capabilities of The George Washington University Student Health Services, in the judgment of Health Services personnel; or
- b. In the event of an accident or emergency requiring immediate medical attention and/or treatment.

2. I agree to assign the benefits of my personal coverage of medical insurance to the appropriate providers of my medical care. In the event that appropriate medical coverage under my medical insurance plan is unavailable, insufficient, or denied with respect to the treatment of services provided to me, I hereby agree to assume all financial liability and responsibility for all expenses and costs associated with said transportation and/or treatment of my illness or injury. I have, in the event that I do not have health insurance for the Student, signed a "Health Insurance Waiver."

3. In consideration of The George Washington University allowing me to participate in the Summer Scholars program and agreeing to intervene on my behalf to provide or make arrangements to provide medical assistance to me as needed, I agree to release, waive, relinquish and forever discharge and indemnify The George Washington University, including, but not limited to, its Board of Trustees, faculty, employees, staff, and other agents from all liability and responsibility for any claims, demands, actions, or other proceedings for any personal injury, accident, illness, damage, wrongful death, expenses, or other loss caused, suffered, or incurred by me or any other person or entity arising out of my participation in the Summer Scholars program wherever or however the same may occur and for whatever period said activities may continue. Furthermore, I do hereby release, waive, discharge and relinquish any action or causes of action, aforesaid, which executors, administrators and assigns prosecute, present any claim for personal injury, property damage or wrongful death against The George Washington University, including, but not limited to, its Board of Trustees, faculty, employees, staff, and other agents for any of said causes of action whether the same shall arise by negligence of any said person or other wise. This release and waiver shall be binding on myself, my heirs, executors and administrators and assigns.

4. I agree to indemnify and hold harmless The George Washington University, its Board of Trustees, its faculty, employees, staff, and other agents against any and all claims or demands, judgments, settlements, costs, or expense relating to the provision of medical care. I understand and agree that The George Washington University assumes no responsibility for any injury or damage which might arise out of or in connection with such authorized emergency medical treatment.

5. I acknowledge that I have read and understand the above statements and that if I am unable to do so, for whatever reason, I have had them read to me and am confident that the individual so doing has read and/or translated the statements truthfully and in their entirety.

Student _____ Date _____

AUTHORIZATION FOR TREATMENT OF STUDENTS UNDER AGE 18

I, _____, (print parent/guardian name) represent that I am the parent/guardian having legal custody of _____ (student name), and that I acknowledge that I have read the foregoing and consent to the above on behalf of my son/daughter/ward.

I hereby authorize my child to hold and dispense the following medication(s) to himself/herself while participating in The George Washington University Summer Scholars program.

Medications: _____ Purpose: _____ Dosage: _____

Parent/Guardian Signature _____ Date _____

Address _____ City _____ State _____ Zip _____