SCHMAHL SCIENCE WORKSHOPS STUDENT RELEASE FORMS

All forms must be received prior to the beginning of the workshop or activity. Please retain a copy for your records.

STUDENT NAME: _____**School**_____

AUTHORIZED PERSONS TO PICK-UP STUDENTS AT THE END OF THE WORKSHOP:

For the Safety of Your Student - Please provide the following information for everyone authorized to pick up your student for release or emergency. A proper form of identification: such as, a California issued Driver's License or a government issued Passport will be required to release a student. Program personnel will not release any student to anyone without proper authorization from the parent/s or guardian/s and without proper identification. Please, make sure you abide by this rule. There will be absolutely NO exceptions. **No student under the age of 14 will be allowed to leave the classroom unescorted.**

CONTACT 1:

PRINT FIRST AND LAST NAME	DRIVER'S LICENSE/ID#	RELATIONSHIP TO STUDENT
CELL PHONE#	**HOME PHONE#**	**WORK PHONE#**

CONTACT 2:

PRINT FIRST AND LAST NAME	DRIVER'S LICENSE/ID#	RELATIONSHIP TO STUDENT
CELL PHONE#	**HOME PHONE#**	**WORK PHONE#**

CONTACT 3:

PRINT FIRST AND LAST NAME	DRIVER'S LICENSE/ID#	RELATIONSHIP TO STUDENT
CELL PHONE#	**HOME PHONE#**	**WORK PHONE#**

If the parent/guardian is attending the class with the student, parent/guardian is not required to show their ID when signing out. If your student is attending more than one class in a single location, you must sign your student in and at dismissal, the attending teacher/s will sign out your student and they will move onto the next class. If SSW is the last class of the day you will be required to sign out your student.

SIGN OUT WAIVER:

If your student is 14-17 years of age and you wish to have them sign themselves out without an escort, please sign this waiver:

I, the undersigned, hereby authorize my student, as named above, to sign themselves in and out of all Schmahl Science Workshops from **AUGUST 1, 20__** through **JULY 31, 20__**. By signing this waiver I have consented and have released Schmahl Science Workshops of any and all liability.

PRINT: PARENT/GUARDIAN'S NAME	PARENT/GUARDIAN'S SIGNATURE	DATE

AUTHORIZATION TO PARTICIPATE:

The student herein described has permission to engage in all activities in the program, except as noted. On behalf of myself and my student, I agree to release and hold harmless Schmahl Science Workshop, its officers, directors, employees, and volunteers from any and all liability for personal injury, death, property damage, or loss of any kind or nature whatsoever, arising directly or indirectly in connection with my student's participation Workshops or activities (except to the extent caused by the gross negligence or willful misconduct of a Schmahl Science Workshops' personnel), including any first aid, medical care, surgery, and hospitalization given or withheld from my student.

PRINT: PARENT/GUARDIAN'S NAME	PARENT/GUARDIAN'S SIGNATURE	DATE

SCHMAHL SCIENCE WORKSHOPS STUDENT RELEASE FORMS

STUDENT NAME: _____

AUTHORIZATION FOR CONSENT TO TREATMENT OF A MINOR:

I, the undersigned, parent/guardian of the above named student, a minor, authorize an employee of Schmahl Science Workshops to consent to emergency medical or dental care, an X-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care that is deemed advisory by, and is to be rendered under the general supervision of any physician or surgeon licensed under the provisions of the Medicine Practice Act, or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, school or Schmahl Science Workshops facility, or elsewhere. I authorize an employee of Schmahl Science Workshops to administer basic first aid when applicable, including the treatment of minor cuts, scrapes, burns and stings.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of an employee of Schmahl Science Workshops to give specific consent to any and all such diagnosis, treatment or hospital care which the physician, surgeon or dentist in the exercise of his or her best judgment may deem reasonable. I agree to assume financial responsibility for all medical and hospital expenses. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California (allows parents or guardians to authorize any adult to consent to medical/dental treatment as stated in paragraph one above).

This authorization shall remain effective from **AUGUST 1, 20__** through **JULY 31, 20__** unless revoked in writing delivered to Schmahl Science Workshops. **Please attach a copy of your student's insurance card to this packet.**

PRINT: PARENT/GUARDIAN'S NAME	**PARENT/GUARDIAN'S SIGNATURE**	**DATE**
HOME ADDRESS	**CITY**	**ZIP**
INSURANCE CARRIER	**POLICY#**	**MEDICAL GROUP#**
NAME OF PRIMARY INSURED	**INSURANCE CONTACT PHONE#**	
PRINT: PHYSICIAN'S NAME & PHONE#	**PRINT: DENTIST'S NAME & PHONE#**	

HEALTH HISTORY:

ALLERGIES:

Please describe your student's allergies as accurately as possible to ensure appropriate emergency responses:

_____

_____

What medication is to be administered in case of an exposure? _____

ASTHMA:

Attacks Triggered By: _____ Frequency of Attacks: _____

Prescribed Medication: _____

Does your student require an **EPI stick**? ❑ Yes ❑ No (***If 'Yes', the*** **MEDICATION PERMISSION** ***must be completed.***)

PAST MEDICAL HISTORY:

Please indicate if your student has a history of the following:

- Diabetes ❑ Yes ❑ No
- Fainting ❑ Yes ❑ No
- Frequent Nosebleeds ❑ Yes ❑ No
- Orthopedic Injury ❑ Yes ❑ No -If 'Yes', please indicate injury: _____
- Skin Disorder ❑ Yes ❑ No
- Seizure Disorder ❑ Yes ❑ No

Please describe any other existing health condition/s that has not been mentioned that would affect the student's participation in class or lab activities: _____

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STUDENT NAME: _____

MEDICATIONS (PRESCRIBED AND/OR OVER THE COUNTER):

Please list all medications given routinely at home prior to the student arriving at the Workshop:

_____

Does the student require medication (Prescription and/or Over the Counter) during Workshop hours? ❑ Yes ❑ No

(***If 'Yes', the*** **MEDICATION PERMISSION** ***must be completed.*** Any prescribed or over the counter medication necessary for your student during Workshop hours requires a physician's order and a parent/guardian release before medications may be dispensed.)

MEDICATION PERMISSION:

If your student needs any medication to be administered during any Schmahl Science Workshop, please complete sections A, B & C. If your student does not need any medication during a SSW, please sign and complete only the waiver at the bottom of this page. If your student has a food allergy and you do not wish to provide medication please complete sections A & the waiver.

SECTION A: COMPLETED BY A PHYSICIAN

has been under my care for

_____ _____

PRINT STUDENT NAME **CONDITION OR DIAGNOSIS**

This medication cannot be taken effectively outside hours.

_____

MEDICATION PRESCRIBED

Please administer the medication as follows:

Dose: _____ Frequency: _____

Route: _____ Time: _____ Duration: _____

_____

MEDICATION: SPECIAL INSTRUCTIONS

_____ _____ _____ _____

PRINT PHYSICIAN'S NAME **SIGNATURE** **TELEPHONE#** **DATE**

SECTION B: COMPLETED BY THE PARENT/GUARDIAN

I have read and understand the top of this form. I hereby grant permission for my student to receive medication as directed by his/her physician.

_____ _____ _____

PRINT: PARENT/GUARDIAN'S NAME **PARENT/GUARDIAN'S SIGNATURE** **DATE**

SECTION C: COMPLETED BY THE PARENT/GUARDIAN

Please deliver your student's medication directly to the workshop supervisor in the original, properly labeled container.

FOR PRESCRIPTION MEDICATION/S, LABELS MUST DISPLAY:

- Student's Name
- Name and Phone # of the Pharmacy
- Physician's Name
- Name, dose, frequency & route of administration of the medicine
- Any other necessary directions

FOR OVER THE COUNTER MEDICATION/S:

All medications must be in the original, manufacture's container with the student's name affixed to the container.

MEDICATION WAIVER:

I, the undersigned, do not wish to provide Schmahl Science Workshops with any medication for my student while s/he is attending Schmahl Science Workshops. In the event that my student requires any medication, I am to be notified immediately and I will pick up my student and tend to his/her needs.

_____ _____ _____

PRINT: PARENT/GUARDIAN'S NAME **PARENT/GUARDIAN'S SIGNATURE** **DATE**