FAU Honors High School String Orchestra
"Side-by-Side" Festival Permission Form

*Required fields

Student First and Last Name	Grade Level	School	____ / ____ / ____ Date of Birth

Mailing Address	City	State	Zip

Daytime Telephone	Email Address

Parent/Guardian First and Last Name	Parent/Guardian Cell Phone	Alternate Contact Phone

Alternate Release Contacts

First and Last Name	Cell Phone
First and Last Name	Cell Phone

Meal Preference: ______________
Regular, Vegetarian, or Gluten-Free

T-Shirt Size:

Does not apply to all programs

Program Name / Session	Program Start Date	Program Fee

Parent/Guardian Authorization

PHOTO/VIDEO RELEASE: I **do/** **do not** hereby give Florida Atlantic University permission to use my child's photograph and/or video image solely for the purposes of University-related promotional material and publications and waive any rights to compensation or ownership thereto.

TRANSPORTATION RELEASE: I give permission for my child to be transported to activities, riding in approved vehicles, or walking with staff to attend and participate in camp-sponsored activities on and off campus, should the program require.

MEDICAL RELEASE: I certify that my child is physically fit to participate and I know of no medical reason why my child should not participate. I also give permission to the leaders of this program to secure emergency medical or surgical treatment for my child if there is insufficient time to contact me, and to secure routine, non-surgical medical care as needed. I have adequate health insurance necessary to provide for and pay for any medical costs that may directly or indirectly result from my child's participation in this PRE-COLLEGIATE PROGRAM. I agree to pay for any medical costs that exceed the limits of my insurance coverage. I do not have medical insurance; I understand the University is not responsible for medical expenses that may directly or indirectly result from my child's participation in this PRE- COLLEGIATE PROGRAM.

PERMISSION AND RELEASE OF LIABILITY: I voluntarily assume full responsibility for any risk of loss, property damage or personal injury, including death, which may be sustained by my child as a result of his/her participation. I hereby release, waive, and discharge Florida Atlantic University and its Board of Trustees, its officers, agents, employees and representatives from all claims, demands, liabilities, rights and causes of action of whatever kind or nature, that may result from or occur during my child's participation in this PRECOLLEGIATE PROGRAM, whether caused by negligence of the UNIVERSITY, its Board of Trustees, officers, agents, employees or representatives or otherwise. I also agree to indemnify and hold harmless the UNIVERSITY for any loss, liability, damage or costs, including court costs and attorney's fees that may occur as a result of my or my child's negligent or intentional act or omission while participating in this PRECOLLEGIATE PROGRAM.

I HAVE CAREFULLY READ THIS PERMISSION AND RELEASE OF LIABILITIES AND HAVE HAD SUFFICIENT TIME TO SEEK EXPLANATION OF THE PROVISIONS CONTAINED HEREIN, AND TO DISCUSS ANY QUESTIONS OR CONCERNS I MAY HAVE WITH THE UNIVERSITY OR ITS AFFILIATE. AFTER CAREFUL CONSIDERATION, I SIGN THIS DOCUMENT VOLUNTARILY AND WITHOUT ANY INDUCEMENT.

Signature of Parent/Guardian*	Date

Permission to Treat or Administer Emergency Medical Care/Authorization to Release Medical Information

I/We, the undersigned Parents/Guardians, in the event of an emergency, give permission for the evaluation and treatment, in our absence, of the above named student as deemed necessary by a currently licensed health care provider, hospital, emergency medical services or camp staff. Every effort will be made to contact the parent/guardian. Care of the injured student will be provided as needed. Care will not be withheld until parent arrives or are notified. I/We understand that the parent/guardian is completely responsible for the financial costs incurred with treatment.

I/We, the undersigned, authorize the release of medical information, gathered in the course of a camp emergency, to the listed medical care providers and emergency response personnel. I/We authorize the listed medical providers to share any "personal health care information" that will support the health of the camper while in program with the designated Health Care staff.

Health Care Provider Information:

Pediatrician/Primary Health Care Provider:____ Telephone:___________________________

Dentist: ____Telephone:______________________

Insurance Coverage Yes No

Company/Carrier Name: ____

Medical History:

My child will take daily or emergency medication during the program day. Yes No (If yes, must complete Authorization to Administer Medication Form)

Does your child routinely take daily medication at home? Yes No If yes, list the name, dose, time given, reason for administration, and any known side effects. ____

Does your child(ren) have any disease or chronic illness we should know about? Please list below.

____

Does your child currently have Asthma? Yes No If yes, list frequency of asthma attacks, date of last attack and meds taken:________________

____

Does your child currently have Allergies? Yes No If your child has a strong allergic reaction to any substance, you are encourage to bring in a completed "Authorization to Administer Medication in Program" form for oral Benadryl and/or an injectable Epi-pen, Epi-pen Jr. These will be kept locked.

Food/Medication Allergies:____ Treatment:____________________________________

Reaction/Reaction Time:____

Contact Allergies (bug bites, airborne vapors, dust, pollen, lotions, latex, etc.):____

Treatment:____ Reaction/Reaction Time:____________________________________

Has your child been diagnosed or treated for a vision, speech, or hearing impairment? Yes No

Does your child wear glasses/contacts or hearing aids: Yes No Explain: ____

Has your child been diagnosed or treated for behavioral, developmental, or learning disabilities? Yes No If yes, please explain:______________

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Does your child require assistance as defined by the Americans with Disabilities Act? Yes No

If yes, please explain: ____

Medication Policy: All routine, regularly scheduled or as needed medications and treatments administered in the program setting must be authorized in advance by a licensed health care provider. This includes nebulizer or inhaler treatments for asthma, medications, ointments, or dressing changes to the skin and all over the counter medication (OTC's) such as Tylenol, Motrin, Cough Medicine, and Cough Drops. A note from the parent/guardian does not authorize the nurse or designee to provide these treatments. Before the nurse or designee can administer any medications or treatments the "Authorization to Administer Medication in Program" form must be completed by the parent/guardian. The parent/guardian must provide to the Director the prescribed medication stored in the original container with an appropriate pharmacy label on each bottle. All labels must include the camper's name, dose, route and time of administration of the medication. No camper is permitted to carry any medication in his/her pocket or backpack unless special permission is granted. All medication will be kept secure in a locked cabinet in the TOPS Office and dispensed by the nurse or designee.

I/We have read and will abide by the program's medication policy. ____

Parent/Guardian Signature Date

Student Behavioral Expectations(Parent/guardian to review and student to sign)

I will treat fellow students, FAU faculty, and staff with respect at all times, including: respectful listening, participation during hands-on activities, avoiding distracting behaviors, and following directions from FAU staff as necessary to ensure a safe and enjoyable experience by all. I understand that the University reserves the right to exclude my participation in this program if my participation or behavior is deemed detrimental to the safety or welfare of others. I understand that cell phones and electronic games are allowed for limited use as permitted during breaks. I understand that the consequences for breaking these rules may include; (1) a warning from the instructor; (2) meeting with the director; (3) a phone call and/or meeting with the parent/guardian; (4) being asked to leave the program without a refund.

____ ____________________________________

Student Signature Date