



A program of the Foundation for Private Enterprise Education, a 501 (c) (3) organization

(FORM # 1)
**2010 Washington Business Week
Summer Programs
Student Medical Information Form
and Photo Release**

SECTION I. ATTENDANCE

I will be attending a Business Week Program at: WESTERN GONZAGA CENTRAL PACIFIC LUTHERAN

SECTION II. GENERAL INFORMATION

New/Corrected Address

1. Name of student _____ (M.I.) _____ Last Name _____

2. Date of Birth _____ Age _____ Grade in school (09/10) _____

3. Ethnicity (for statistical purposes only): African American / Black Asian / Pacific Islander Caucasian / White
 American Indian / Aleutian Hispanic / Latino Other _____

4. Address _____

City/State/Zip Code _____ County _____

Home Phone _____ Student Cell (_____) _____

5. Parent/Guardian Name _____

Home Address of Parent/Guardian (if different from student) _____

City/State/Zip _____

6. Telephone of Parent/Guardian Home (_____) _____ Work (_____) _____

Cell (_____) _____ Other (_____) _____

SECTION III. MEDICAL INFORMATION

1. Are you taking any prescription medications? _____
If so, what? _____

2. Do you have any allergic reaction to any of the following: Insects Food Penicillin Plants
Other (please specify) _____

3. Do you have any specific health problems or special needs that would affect your ability to participate in an active program?

4. Do you have a history of: Convulsions or Epilepsy Diabetes Asthma Heart Trouble
 Other _____

5. Are you currently limited in physical activity? (YES or NO) _____
If yes, please specify: _____

6. Physician's name and phone number _____

7. Are you covered by medical insurance? (If not, please contact the Business Week office.) _____

Specific Company _____

Name of Policy Holder _____ Group Number _____

Policy/member Number _____

(Continued on Reverse)

SECTION IV. AGREEMENT AND CONSENT FOR TREATMENT AND WAIVER OF LIABILITY

Should the student named herein require medical treatment or hospitalization for any accident or illness during Washington Business Week, the attending physician and/or hospital is authorized to release such diagnostic and treatment information as may be needed to complete any insurance claim. It is agreed that any and all medical expenses incurred by the student for accidents or illnesses occurring during Washington Business Week are NOT the responsibility of Washington Business Week or the host university.

_____ (Initials)

In addition, this is to certify that I, the undersigned parent/guardian, hereby consent to and authorize the administration and performance of all needed medicines (and surgical treatment) and the administration of any anesthetic which, in the opinion of the attending physician, may be necessary and advisable in the event of any medical emergencies regarding the named student. As the undersigned parent/guardian, I hereby authorize the administration of over-the-counter medications (i.e. aspirin, tylenol, antacids, ibuprofin, cough drops, etc.) by Washington Business Week staff to the student named herein.

_____ (Initials)

I, the parent or legal guardian of the above named student, do hereby agree to release and hold harmless the Foundation for Private Enterprise Education d.b.a. Washington Business Week, its officers, directors, employees and agents from and against any and all actions, claims, costs, losses, expenses and/or damages, including attorney's fees, arising out of or resulting from my child's attendance at a Washington Business Week program, except due to the sole gross negligence or willful misconduct of the Foundation for Private Enterprise Education d.b.a. Washington Business Week.

_____ (Initials)

SECTION V. PHOTO RELEASE

The undersigned hereby releases any photos, video or likenesses of the participant named in this form taken by Washington Business Week (BUSINESS WEEK), to be used for promotional and publication materials. Washington Business Week does not attach names to photos without permission.

By signing below, I am indicating that I have read the provisions of this form, understand them, and agree to them.

Student's Name: _____ (Print or Type) _____ (Signature)

Parent/
Guardian Name: _____ (Print or Type) _____ (Signature)

_____ (Date Signed)

Please give the name and phone number of **two** people to call who will assume responsibility for your son or daughter in case of an emergency during their time at Washington Business Week if we are unable to reach you.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

Please complete and mail to:
Washington Business Week
33305 1st Way South, Suite B212
Federal Way, WA 98003

NOTE: We **cannot** admit any student to Washington Business Week without this completed form with the correct information. Our insurance carrier and our program require we have this information. We must ensure proper medical treatment can be made available to all participating students in case of emergencies. **Thank you.**

IMPORTANT! Please return this form within 3 weeks!