

# NEW ENGLAND SUMMER YEARBOOK WORKSHOP

Monday - Tuesday, June 26-27, 2017 • Bryant University

One Medical Release Form is required for **each** adviser and student participant.

Students must also have page 2 completed, signed and returned in order to participate.

Please make checks payable to: **Jostens Summer Workshop**

**NO WORKSHOP REFUNDS AFTER** June 16, 2017

School: \_\_\_\_\_

## Participant Information:

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Participant Email Address: \_\_\_\_\_

I do \_\_\_ I do not \_\_\_ give my permission for photos to be taken of me at this workshop to be used on next year's promotional materials (brochure, website and social media).

I need ADA accessibility.

I will arrive on Sunday night.

## Liability Release

**Emergency Contact Information:** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

If emergency treatment is required, my health insurance plan number and carrier are:

Insurance Company: \_\_\_\_\_ Policy No.: \_\_\_\_\_

List any pertinent medical information applicable to allergies, nervous disorders, heart trouble, diabetes, epilepsy, medications etc.: \_\_\_\_\_

\_\_\_ I am on a special diet (*vegan, kosher, allergies etc*). Please explain: \_\_\_\_\_

Please list the date of last tetanus shot: \_\_\_\_\_

**Please include any additional information which you feel may be pertinent to the student's safety while he or she attends the workshop on a separate piece of paper and attach it to this medical release.**

In consideration of the educational opportunity provided to the above-named student or adult, I/we the parent(s), legal guardian(s) or spouse, or myself, do hereby hold harmless, release and forever discharge Jostens, Inc., all Jostens representatives and the Bryant Univeristy at which the workshop will be held, and their officers, agents and employees from any and all claims, demands, liability, actions, causes of action, attorney fees and expenses on account of damages to personal property or personal injury, which may result from causes beyond the control of and/or without the fault or negligence of Jostens, Inc., Jostens sales representatives and employees, and Bryant Univeristy and their officers, agents and employees, during the workshop.

\_\_\_ **My student will be arriving early on Sunday June 25th. I know that the workshop has not offically begun therefore there will be no adult supervision or meals provided.**

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(parent/guardian if participant is under age of 18)

Printed Name \_\_\_\_\_

Students Participants must have **page 2** completed and signed in order to attend workshop.

**This page for student participants  
under the age of 18 only.**

**Health History:**

Student Name: \_\_\_\_\_ D.O.B \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Heart troubles (explain): \_\_\_\_\_

Seizures/Convulsions (explain): \_\_\_\_\_

Diabetes (Detail of treatment & control): \_\_\_\_\_

Asthma or Bronchitis: \_\_\_\_ *Circle one:* Uses inhaler daily / as needed Inhaler sent with student: \_\_\_\_

Allergies: Bee Sting: \_\_\_\_ Penicillin: \_\_\_\_ Food: \_\_\_\_ Environmental: \_\_\_\_ EpiPen sent with: \_\_\_\_

Type of Reaction and Severity: \_\_\_\_\_

Other (explain): \_\_\_\_\_

Are there any conditions/illnesses for which this student is currently receiving treatment or medication?

No: \_\_\_\_ Yes: \_\_\_\_ Explain: \_\_\_\_\_

Please describe and list any current medications: \_\_\_\_\_

Does the student have the medication in his/her possession? Yes: \_\_\_\_ No: \_\_\_\_

*Please see below for a list of over the counter medications.*

**Permission for Dispensing of Over-the-Counter Medications**

Please initial below:

\_\_\_\_ Ibuprofen (Advil, Motrin)

\_\_\_\_ I am sending my child with other OTC Meds I would like the staff nurse to dispense.

OTC Medication: \_\_\_\_\_

*\*medication will need to be give to nurse at the time of workshop registration on Monday June 26th.*

\_\_\_\_ **I do not want my child to receive ANY over the counter medications during the workshop.**

**IN CASE OF EMERGENCY, I HEREBY AUTHORIZE ANY LICENSED PHYSICIAN, HOSPITAL, CLINIC OR OTHER MEDICAL FACILITY TO HOSPITALIZE AND SECURE PROPER TREATMENT FOR MY CHILD NAMED ABOVE.**

*No student will be allowed to participate without this form properly completed and returned.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name \_\_\_\_\_