**Parent/Guardian Consent, Medical Release and**

**Release from Liability Agreement**

**University at Buffalo School of Pharmacy and Pharmaceutical Sciences (SPPS)**

**Pharmacy Summer Institute**

**Please complete the following form and mail to:**

**Jennifer Rosenberg, 270 Pharmacy Building, SPPS – Buffalo, New York 14214-8033 no later than July 1**

**Please read the following information carefully before signing.**

Summer Workshop: SPPS Pharmacy Summer Institute

Dates: July 13-15, 2020

Participant Name:

Parent/Guardian Signature:

In consideration for allowing Participant to participate in a Pharmacy Summer Institute, I/we, as parents and/or guardians of Participant, agree to the following:

* Authorize Participant to participate in the Pharmacy Summer Institute for the dates stated above.
* Release, indemnify and hold harmless the University at Buffalo SPPS Pharmacy Summer Institute from any and all damages, except for damages caused by the sole gross negligence or intentional misconduct of the University at Buffalo, arising out of the participation of Participant in the Institute.
* Prior to the commencement of the Institute, I/we were made aware of the nature of the Institute, had sufficient opportunity to inquire further, and understand the Institute has inherent risks and I/we and Participant assume, on behalf of Participant, all those inherent risks.
* While participating in the Institute, Participant is subject to the policies, rules and regulations of the University at Buffalo Pharmacy Summer Institute. Possession of fireworks, explosives, any weapon, illegal drugs or alcohol is prohibited and cause for immediate expulsion from the Institute. Further, any Participant repeatedly disobeying University policies, rules or regulations may be expelled from the Institute.
* Authorize University at Buffalo Pharmacy Summer Institute, its employees, clinicians, athletic trainers, nurses and agents (collectively, “Activity Sponsor”) the authority to seek, obtain, and approve any medical care and treatment including, but not limited to x-ray examination, anesthetic, medical, dental or surgical diagnosis, or treatment and medical care which may be recommended and provided under the general supervision of any physician or surgeon, for Participant which, in their judgment, is necessary for the health and well-being of Participant during his/her participation in the Institute. I/We further agree that I/we are(am) solely responsible for any costs incurred and agree to hold the University at Buffalo, their employees and agents (collectively, “University”) harmless for any liability arising out of any good faith action taken in obtaining medical treatment for Participant.

The above agreements are binding upon us, our estates, heirs, representatives and assigns.

Parent/Guardian Signature Date

**HEALTH INSURANCE INFORMATION SHEET**

**REQUIRED FOR ALL ATTENDEES**

Private insurance information must be provided, if applicable. Please be advised that, should a participant require medical attention, **you are responsible for paying any costs not covered by insurance.**

Participant’s Name Date of Birth

Participant’s Address City & State

Participant’s Phone Number Zip Code

Insurance Company Name Effective Date

Address of Insurance Company

City & State Zip Code

Phone # of Insurance Company Group #

Policyholder’s Name Policy #

Policyholder’s Address City & State

Relationship to Participant Zip Code

Contract # Employee #

**I hereby authorize the release of any medical information which might be needed in connection with payment for medical services.**

**I request that payment under my medical insurance program be made directly to the provider on any bills for services rendered by that provider. I understand that I am financially responsible for all costs not paid by my medical insurance program.**

 Parent/Guardian Signature Date

 Parent/Guardian Signature Date

**EMERGENCY INFORMATION & CONTACTS**

***Please complete this form in its entirety. This information will be helpful in the unlikely event of an accident or sudden illness.***

Personal physician contact information:

 Name of Personal Physician Phone

 Physician Address

 City & State Zip Code

Person(s) to be contacted in case of emergency:

 Name Relationship

 Address

 City & State Zip Code

 Daytime Phone Evening Phone Cell Phone

Person(s) to be contacted in case of emergency:

 Name Relationship

 Address

 City & State Zip Code

 Daytime Phone Evening Phone Cell Phone

**IMMUNIZATION RECORD**

**REQUIRED FOR ALL ATTENDEES**

**Please fill out this form completely or attach a physician’s immunization record**

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| --- | --- | --- | --- |
| **Vaccination** | **Vaccine Date****(mm/dd/yr)** | **Or Physician Diagnosed Disease** | **Or Serology Results/Date** |
| Diptheria |  |  |  |
| Haemophilus Influenza B (HIB) |  |  |  |
| Hepatitis B |  |  |  |
| \*Measles\* |  |  |  |
| \*Mumps\* |  |  |  |
| \*Rubella\* |  | **History of Rubella disease does not prove immunity** |  |
| \*\* OR Combined MMR \*\* |  |  |  |
| Poliomyelitis |  |  |  |
| Tetanus |  |  |  |
| Varicella (chicken pox) |  | Or year of illness |

**Other Medical Conditions**

* Are there any recent/current illness/injury/existing medical conditions that the Institute should be aware of?

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* Are there any restrictions or limitations that need to be placed on your child’s physical activity?

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* Are there any special dietary needs the Institute needs to be aware of?

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* Are there any allergies (i.e. medications, food, insect stings, etc.)?

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* Please list any other concerns medical concerns:

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* Does the Instituteer carry an Epi-Pen?
* Does the Instituteer carry an inhaler?

**Summer Workshop:** SPPS Pharmacy Summer Institute

**Dates:** July 13-15, 2020

**PHOTOGRAPHY RELEASE**

**Name of Student Participant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Parent/Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below:

* I hereby authorize University at Buffalo – SUNY and/or SPPS Pharmacy Summer Institute to publish photographs taken on July 8, 2019 through July 10, 2019 of myself and/or the student participant listed above, and our names and likeness, for use in the University’s print, online and video-based marketing materials, as well as other University publications.
* I hereby release and hold harmless University at Buffalo from any reasonable expectation of privacy or

confidentiality for myself and for the student participant listed below associated with the images

specified above. Further, I attest that I am the parent or legal guardian of the student participant listed

below and that I have full authority to consent and authorize University at Buffalo to use their likenesses

and names.

* I further acknowledge that participation is voluntary and that neither I, nor the student participant will

receive financial compensation of any type associated with the taking or publication of these

photographs or participation in University marketing materials or other publications. I acknowledge and

agree that publication of said photos confers no rights of ownership or royalties whatsoever.

* I hereby release University at Buffalo, its contractors, its employees and any third parties involved in the

creation or publication of University publications, from liability for any claims by me or any third party in

connection with my participation or the participation of the student participant listed below.

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

**TRANSPORTATION RELEASE**

**Name of Student Participant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student Participant Cell Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Parent/Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

While participating in SPPS Pharmacy Summer Institute, students will take two field trips and Rochester-area students will be bussed to and from Rochester, New York. When these excursions occur, students will travel off of the University at Buffalo’s South Campus. Transportation will be provided by the Institute to and from the sites. For this reason, please agree to the following by signing below:

* I give permission for my student to travel off of the University at Buffalo’s South Campus during the

duration of the above Institute via the transportation provided by the Institute.

* If from the Rochester area, I give permission for my student to travel to and from the Rochester area to Institute

via the transportation provided by the Institute.

* I assume all risks and hazards and hereby waive, release, absolve, indemnify and agree to hold

harmless the University at Buffalo – SUNY and SPPS Pharmacy Summer Institute, as well as its directors, officers, administrators, employees, or other agents from any and all liability, actions, lawsuits, claims, demands and expenses resulting, directly or indirectly, from loss of life, personal injuries, property damage, or other damage suffered by my Institute participant while traveling to or from off-campus sites.

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