



RESEARCH THE POSSIBILITIES....
 THE TWELFTH ANNUAL
 NCSSSMST STUDENT RESEARCH SYMPOSIUM
 June 2-5, 2005

MEDICAL AUTHORIZATION FORM

Please have your parent or guardian sign this form and return it to your accompanying teacher by May 10, 2005 to be faxed.

STUDENT RESEARCH SYMPOSIUM PARTICIPANT: _____
 Name

AUTHORIZATION - I consider the above named Student Research Symposium participant to be in good health, and permission is granted to participate in all activities, unless otherwise indicated on this record. In case of illness and/or injury, permission is granted for medical treatment to be rendered to my son/daughter. I understand that I will be notified in case of serious illness. All medical bills incurred by the patient will be the responsibility of the parent or guardian. [Please Note: We do not bill insurance companies, but will furnish an itemized statement, complete with necessary information to be submitted by the insured.]

Name of Health Insurance Carrier

Policy Number: _____

Any specific activities restricted? _____ Please list _____

Any special medical or dietary plan? _____ Please specify _____

Any known allergies to medication? _____ Please list _____

Special accommodation: _____

Suggestions or comments from parent or guardian in regard to special health areas, such as diabetes, epilepsy, sleep-walking, recent exposure to communicable diseases, allergies, etc. which would aid us in providing a safe and pleasurable program experience for your son or daughter:

SIGNATURE OF PARENT OR GUARDIAN

NAME: (PARENT OR GUARDIAN)

In case of an emergency, I can be reached during the day at () _____ and during the evening at () _____.

PLEASE INCLUDE A PHOTOCOPY OF THE INSURANCE CARD ALONG WITH THIS FORM AND FAX TO 610-519-6450, ATTENTION GINA SEMENTELLI

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