Please Print Information Clearly in Black or Blue Ink
In the event your son/daughter needs medical attention for an illness or injury while attending our program, the following medical information will be necessary. Students should carry their medical cards and/or medical information with them at all times.

**General information (to be filled out by Parent/Guardian)**

**Please Print**

1. Participant’s Name: __________________________________________________________________________
   (Last Name)  (First Name)  (Middle Initial)

   Cell Phone: ___________________________  Date of Birth: _______________________
   (MM\DD\YY)

   Address:
   (House/Apartment Number)  (Street Name)  (City, State)  (Zip Code)

   Email Address: ____________________________________________________________________________

   Infinite Campus Username: _____________________  Infinite Campus Password: __________

2. Mother’s Name: ____________________________________________________________________________
   (Last Name)  (First Name)  (Middle Initial)

   Home Phone: ___________________________  Cell Phone: _______________________

   Address:
   (House/Apartment Number)  (Street Name)  (City, State)  (Zip Code)

   Mother’s Employer’s Name: _____________________  Phone: __________________

   Mother’s Employer’s Address:
   (House/Apartment Number)  (Street Name)  (City, State)  (Zip Code)

   Mother’s Email Address: __________________________________________________________________

3. Father’s Name: ____________________________________________________________________________
   (Last Name)  (First Name)  (Middle Initial)

   Home Phone: ___________________________  Cell Phone: _______________________

   Address:
   (House/Apartment Number)  (Street Name)  (City, State)  (Zip Code)

   Father’s Employer’s Name: _____________________  Phone: __________________

   Father’s Employer’s Address:
   (House/Apartment Number)  (Street Name)  (City, State)  (Zip Code)

   Father’s Email Address: __________________________________________________________________

**Person To Be Notified In Case Of An Emergency:**

4. Name: ____________________________________________________________________________
   (Last Name)  (First Name)  Phone: _______________________

   Address:
   (House/Apartment Number)  (Street Name)  (City, State)  (Zip Code)

   Relationship to Participant: ______________________________  (Mother, Father, Grandmother, etc)
5. Does the Participant have medical insurance? Yes_______No_________
   If yes, please provide a copy of the front and back of your insurance card.

6. Is the participant allergic to any foods or medication? Yes_______No_________
   If yes, please list the foods and/or medication:

   _______________________________________________________________________
   _______________________________________________________________________

7. List any Medications the participant is presently taking, including dosage and how often:

   _______________________________________________________________________
   _______________________________________________________________________

8. Present Health (List any current physical conditions):

   _______________________________________________________________________
   _______________________________________________________________________

I certify that all the information given in this Medical History Form is true and correct to the best of my knowledge.

The undersigned, parent or legally appointed guardian of ________________________,
   (Please print name of participant)

   a minor, hereby authorize(s) the administration of the University of Nevada, Las Vegas Upward Bound Math & Science Center, as agent for the undersigned, to consent to any X-Ray examination, anesthetic, medical or surgical diagnosis and treatment or hospital care which is deemed advisable by and rendered under the general supervision of any physician, surgeon, or nurse practitioner licensed under the provisions of Nevada's Practice Act. I, the undersigned, also acknowledge that I am responsible for payment of hospital and/or medical bills incurred for such treatment. This authorization is given pursuant to the provisions of the Nevada Revised Statutes, and shall remain in effect as long as the Participant is in the University of Nevada, Las Vegas Upward Bound Math/Science Center.

Dated this _______ day of ____________________, 2018.

Signed: ___________________________________________  ___________________________
   Student Signature                                      Print Name

Signed: ___________________________________________  ___________________________
   Parent or legally appointed guardian signature        Print Name

Relationship to Participant: _____________________________
   (Aunt, Uncle, Grandmother, etc.)
Assumption of Risk/Release of Liability Agreement
and Consent to Emergency Medical Treatment
(Minor Participants)

I, _______________________________________________ ("Parent"), in consideration of my child’s Participation in the UNLV Upward Bound Math & Science Center Summer Residential Program ("Event"), on behalf of myself, my assigns and my heirs, expressly and knowingly agree to indemnify, defend and hold harmless the Board of Regents of the Nevada System of Higher Education, on behalf of the University of Nevada, Las Vegas (hereinafter “Sponsor”), its officers, agents, employees and volunteers, for any and all claims, demands and/or causes of action for property damage, personal injury or death sustained by my child arising out of the Event conducted by or under the auspices of Sponsor, including, but not limited to, the selection and/or provision of emergency medical services. In consideration of my child being permitted by Sponsor to use its facilities and/or participate in the Event, I agree to the following:

I understand and agree that Sponsor cannot control all of the risks associated with the Event, and may need to respond to accidents and other emergency situations. Therefore, I hereby give my consent to the administration of any medical treatment that may be deemed by Sponsor to be required for my child relative to his/her participation, with the understanding that the costs of such treatment will be my sole responsibility. I agree to hold UNLV, its officers, agents, volunteers and employees harmless from all costs associated with such treatment. I acknowledge that Sponsor does not carry medical or any other insurance for participants in the Event. Therefore, I must provide my child with his/her own medical, disability or other appropriate insurance.

By signing this Agreement, I acknowledge the inherent risks associated to my child for participating in the Event and that such risks include, but are not limited to, the following:

- Risk of physical injury, illness, accident or death in traveling to and from, and participating in, the Event;
- Property loss, theft or damage;
- Exposure to dust, gas, fumes or chemicals;
- Tripping, slipping or falling;
- Problems related to exposure to the elements: for example, heat exhaustion, dehydration, sunburn, frostbite, and allergic reactions.

I hereby certify that my child is in good physical and mental health and has had no pre-existing, medical conditions or injuries affecting his/her ability to participate in the Event, nor has he/she been declared medically ineligible for any athletic competition.

I hereby grant to UNLV the right to photograph, videotape or otherwise digitally collect my child’s likeness, voice and sounds. I understand that video and/or audio recordings taken of my child by UNLV shall be used for educational purposes and to promote such purposes, including dissemination of information for public service announcements.
I understand that UNLV is committed to providing equal access to its programs and services for students who experience disabilities. The Disability Resource Center (DRC) was established to support these goals and to provide assistance with college learning through provision of recommended academic adjustments, auxiliary services, and advocacy. Students with disabilities who may require a reasonable accommodation to participate in the Program must submit a request for an accommodation in writing to the DRC. Please see the DRC’s website for additional information: http://studentlife.unlv.edu/disability.

This Agreement contains the entire agreement between the parties, and supersedes any prior written or oral agreements between them concerning the Event. The provisions of this Agreement will continue in effect after the conclusion of the Event, whether said conclusion is by agreement, operation of law or otherwise.

I have read the foregoing Agreement and have knowingly and willingly signed it with a full understanding of its purpose. I affirmatively represent that I am competent to execute this Agreement, intend to be bound by it, and agree that it shall be governed by the laws of the State of Nevada. I further understand that all incidences of noncompliance with any Event rules will result in my child’s dismissal from the Event.

Parent or Guardian’s Name: _______________________________________________________
Local Address: __________________________________________________________________
Phone #: _______________________________________________________________________

Parent or Guardian’s Signature ____________________ Date ____________________

EMERGENCY NOTIFICATION INFORMATION:
Child’s Name: _________________________________________________________________
Date of Birth: __________________________________________________________________
Emergency Contact’s Name: _____________________________________________________
Emergency Contact’s Address: ___________________________________________________
Emergency Contact’s Phone #: ___________________________________________________
Parents and Guardians,

We are pleased to inform you that the UNLV Upward Bound Math & Science Center (UBMSC) launched the official UNLV Upward Bound Facebook group page on Saturday, May 19, 2012. Shortly thereafter, UBMSC launched a Twitter page as well. UBMSC social media pages provide an online space where the staff can share vital information and interact with participants, parents and stakeholders. The UNLV Upward Bound social media pages provide links to various websites for college admissions, scholarship opportunities, SAT test dates, financial student aid, career exploration, etc. In addition, this page keeps you and your child abreast of upcoming UBMSC and college related events. The pages are also designed for your child to keep in touch with his/her UBMSC counselor if he/she needs help or has any questions. When the group administrator posts information on the social media pages, such as a link to an article, other members will have access to view the information. Additionally, the group administrator could post a study question to the group. All students who follow our pages, will have the opportunity to reply. Think of this as an opportunity to extend learning outside the classroom walls of the traditional classroom. Parents are encouraged to follow us to receive updates as well.

If you have any further questions, please do not hesitate to contact us at (702) 895-4777.

This parental consent form is to both inform you and to request permission for your son/daughter to access the UNLV Upward Bound Math & Science Center social media pages (Facebook & Twitter). The student will be added to the group only upon receipt of this signed consent form. Photo/image and personally identifiable information will be published on the UBMSC social media pages for students who have a signed publicity permission slip on file with UBMSC.

Parent Initial

☐ I/We GRANT permission for my child ________________________________ to access and use the UNLV Upward Bound Math & Science Center social media pages.

Parent Initial

☐ I/We DO NOT GRANT permission for my child ________________________________ to access and use the UNLV Upward Bound Math & Science Center social media pages.

Print First Name: _______________________________ Print Last Name: _______________________________

Student ID#: ________________________________

_________________________________________    __________________________________________

Print Parent Name                                         Parent Signature

_________________________________________    __________________________________________

Parent Telephone #                                         Parent Email Address
Dear Parent(s)/Guardian:

Throughout the Upward Bound Math & Science Center Summer Residential Program, we are asked to take part in publicity releases by way of pictures, newspaper articles, websites, radio time, television and/or video. If you do or do not want your child’s picture or name to be used in such publicity releases, indicate your desire below.

______________ I authorize CAEO & UNLV Upward Bound Math & Science Center to use the student’s name, statements and likeness, without charge, for promotional purposes in CAEO & Upward Bound Math & Science Center publications, advertising, video, and other formats.

______________ I do not authorize CAEO & UNLV Upward Bound Math & Science Center to use the student’s name, statements and likeness, without charge, for promotional purposes in CAEO Upward Bound Math & Science Center publications, advertising, video, and other formats.

____________________________________________________
Signature of Parent or Guardian

____________________________________________________
Signature of Both Parents Please

____________________________________________________
Date
I acknowledge receipt of the UNLV Upward Bound Math & Science Center expectations and progressive disciplinary policy. I have read, understand and agree to the policy. Additionally, I acknowledge that academic misconduct will result in program suspension.

**DISCIPLINARY POLICY**

The UNLV Upward Bound Math & Science Center is committed to the success of every participant. To ensure the success of every student, the staff will take the following responses to actions which are inappropriate or are not conducive to a successful learning environment.

1. The student will receive verbal redirection from a staff member.
2. A conference will be held with the student and a staff member. At this time the student will participate in the creation and implementation of a corrective behavior plan.
3. The parent of the student will be notified of the inappropriate action.
4. The student will enter into a **written contract** with the parent(s) and staff.
5. Failure to comply with the written contract will result in administrative action, which may include suspension or required parental participation.

___________________________________       ________________________________________
Print Student’s Name                      Student Signature

___________________________________         _______________________________________
Print Parent/Guardian Name                Parent/Guardian Signature

_________________________                      ___________________________
Date                                              Date
CLARK COUNTY SCHOOL DISTRICT
FIELD TRIP PERMIT

Last Name of Pupil ____________________________________________
First Name ____________________________________________

I request that my child be allowed to participate in an authorized Clark County School District Field Trip. I understand that my child will be chaperoned by a responsible adult while away from the school, who will take reasonable precautions to protect my child from harm and injury.

I understand that this is a supervised activity. In order to maintain order, students will be expected to comply with rules, standards, and instructions for student behavior. I waive and release all claims against Clark County School District employees or their agents arising out of my child's failure to remain under such supervision. If at any time my child's behavior is incompatible with the standard for student behavior, his/her further participation may not be permitted.

In the event that my child is injured, becomes ill, or involved in an accident while away, I understand that the chaperon will seek medical attention for my child, and the school will contact me as soon as possible, and that I will be financially responsible for medical treatment. I further agree to hold the Clark County School District, its employees, and agents harmless for any injury or illness caused by the negligence of persons other than employees or agents of the Clark County School District when such injury or illness occurs during the trip.

Signature ____________________________________________
Date ____________________________

Home Phone: ____________________________
Work Phone: ____________________________

Emergency Phone and Name: ____________________________

Please note any medical information which would be of help: (i.e., allergies, medications to avoid, current medications, etc.)

I do not wish my child to take part in the school field trips.

Signature of Parent or Guardian ____________________________________________
Date ____________________________

CLARK COUNTY SCHOOL DISTRICT
PERMISO PARA EXCURSION

Apellido del Alumno ____________________________________________
Nombre ____________________________________________

Deseo que mi hijo/a participe en excursiones autorizadas por el Distrito Escolar del Condado de Clark. Tengo entendido que una persona adulta responsable supervisará a mi hijo/a mientras este fuera de la escuela, y se tomarán las medidas necesarias para ofrecer protección en contra de daños y perjuicios.

Tengo entendido que esta es una actividad supervisada. Para mantener el orden, los alumnos deben cumplir con el reglamento y las instrucciones de conducta que se impongan. En caso de que mi hijo/a no obedezca los reglamentos y resulte en cualquier incidente, renuncio y cedo todas las reclamaciones en contra de empleados del Distrito Escolar del Condado de Clark o sus representantes. Si mi hijo/a rehúsa obedecer o su comportamiento es deficiente, participación en futuras actividades no se autorizarán.

En caso de que mi hijo/a sufra un accidente y se lastime durante la excursión, tengo entendido que la persona responsable por el/ella conseguirá atención médica inmediatamente y que la escuela me notificará tan pronto sea posible así como yo soy responsable por los gastos médicos incurridos. Además, no haré responsable al Distrito Escolar del Condado de Clark o a sus representantes si mi hijo/a sufre algún accidente o enfermedad causada por negligencia de personas ajenas al Distrito Escolar del Condado de Clark.

Firma ____________________________________________
Fecha ____________________________

Teléfono de su Casa: ____________________________
Teléfono del Trabajo ____________________________

Teléfono de Emergencia y Nombre: ____________________________
Por favor indique información que nos pueda ayudar:(i.e., alergias, medicamentos que debemos evitar, medicamentos que se estén tomando, etc.)

No deseo que mi hijo/a participe en excursiones escolares.

Firma del Padre o Tutor ____________________________________________
Fecha ____________________________
STUDENT MEDICAL PERMISSION FORM

New form must be completed for each trip
(Please print or type)

Student Name: ____________________________ Sex: ______ Date of Birth: ____________

Last First MI

Student ID: ____________________________ Address: ____________________________
Number & Street ____________________________ City ______ State ______ ZIP

Home Phone: ( _____ ) __________________ School: ____________________________ Teacher: ____________________________

Field Trip Destination: ____________________________ Date(s) of Trip: ____________________________

Emergency Information

Parents/Guardian Name(s): __________________________________________________________________________

Cell/Work/Home Phone: ( _____ ) ____________________________ or ( _____ ) ____________________________

Emergency Contact (If parents cannot be reached): ____________________________ Phone Number: ( _____ ) ____________________________

Physician’s Name: ____________________________ Phone Number: ( _____ ) ____________________________

Medical and Prescription Information

Does your student have any health conditions?  ☐ Yes  ☐ No  If yes, please describe: __________________________________________________________

Will your child be attending a field trip that extends beyond regular school hours?  ☐ No  ☐ Yes
If your child requires medication or a health procedure that is not administered at school, the health office will need appropriate paperwork and Licensed Health Care Provider (LHCP) orders at least ten days prior to the trip. For questions, concerns, or to obtain the required forms, please contact your child’s school health office.

Please check the appropriate box below:

☐ My child does not require any medication on the field trip.

☐ My child requires an inhaler or Epi-pen.

• Licensed Health Care Provider Orders and CCF 643 Parent/Guardian Permission Form are required.

• Per NRS 392.425, permission is required from your Licensed Health Care Provider for your student to carry and self-administer these medications. (Obtain this form HS-96 in the Health Office)

☐ My child requires diabetic care during the field trip.

• Extended care orders are required for care outside of the school day.

• Licensed Health Care Provider orders and CCF 643 Parent/Guardian Permission Form are required.
☐ My child requires medication or a health procedure during the field trip.
   • Medications must be in an appropriately labeled bottle from the pharmacy and less than 1 year old.
   • Over the counter medications require a prescription from a Licensed Health Care Provider and must be in the original container. The prescription must include student’s name, dose, time, and indication for use.
   • Licensed Health Care Provider orders and CCF 643 Parent/Guardian Permission Form are required.

☐ FOR SECONDARY STUDENTS ONLY: My child is able to self-administer his/her medication (except for controlled substances) during the field trip.
   • Medications must be in an appropriately labeled bottle with a written statement that the student may carry and self-administer the medication.

The following medications/procedures are required:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Time(s)</th>
</tr>
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<tbody>
<tr>
<td>Medication</td>
<td>Dose</td>
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</tr>
<tr>
<td>Medication</td>
<td>Dose</td>
<td>Time(s)</td>
</tr>
</tbody>
</table>

Health Procedure (Licensed Health Care Provider orders required) Time(s)

If medical information/needs change during the school year, please contact the school nurse.

I, the parent or legal guardian of __________________________ (my child), authorize and direct the Clark County School District (CCSD) to obtain medical care for my child in the event such care is reasonably necessary. I understand that, if possible, I will be contacted in the event my child requires medical attention. I grant to a licensed health care provider or accredited hospital permission to perform any reasonably necessary medical and/or surgical procedures that are essential for the treatment of my child and agree to be responsible for payment for such care. I release CCSD, its employees, and agents from any damages, liability, or loss resulting from the exercise of discretion in securing in good faith medical care for my child.

Parent/Guardian Print __________________________ Parent/Guardian Signature __________________________ Date __________________________

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