



Media Release

Help us tell the Future Connections story. With your approval, images, video footage, and creative work from your child's experience in the program will allow us to continue funding and expanding Future Connections for generations to come.

Student Name

Parent Name

Parent Phone Number

Permission (select one)

- Deny permission to use my child's image at all
- I was my child's image used within the Future Connections setting only (not in the larger community)
- Limited usage: I want my child's image used for educational materials only (not marketing). This could be either within Future Connections or in the larger community. One example of this could be videos in parent education classes
- Limited usage: I want my child's image used on printed materials only (no digital or video use)
- Unrestricted usage: I give unrestricted permission for my child's image to be used in print, video and digital media. I agree that these images may be used by Future Connections for a variety of purposes and that these images may be used without further notifying me. I do understand that my child's last name will not be used in conjunction with any video or digital images.

Parent Signature

Date



Medical Release

Parent Name

Parent Phone

Student Name

Date of Birth

Gender

School

Parent/Guardian Home Address

City

State

Zip

Student Medical History

Has your child have any of the following conditions:

- Alcohol/drug abuse
- Asthma
- Diabetes
- Eating Disorders
- Emotional Problems
- Hay Fever
- Heart Disease
- Hepatitis
- High Blood Pressure
- Kidney Disease
- Menstrual Problems
- Migraine Headache
- Pneumonia
- Rheumatic Fever
- Seizures
- Thyroid Trouble
- Tuberculosis
- Ulcers



Please List any surgeries your child has had

Date of Last Tetanus Shot

Any other pertinent medical information

If you child need accommodation for the any physical limitations or handicaps, please list

Allergies

Please list any allergies; including serum, drug, and medication allergies

In Case of Emergency

Primary Guardian Contact Information

Name

Home Phone

Work Phone

Place of Work



Alternate Contact Information (2 people)

Name

Home Phone

Work Phone

Place of Work

Name

Home Phone

Work Phone

Place of Work

Family Physician

Doctor's Name

Doctor's Phone

Health Insurance

Name of Insurance Company or county providing medical assistance

Policy #

Expiration Date



Please initial under **ONE** statement to either accept or refuse emergency treatment

ACCEPTANCE OF HEALTH SERVICE
EMERGENCY TREATMENT

If my child should become ill or injured on any field trip sponsored by the University Circle Inc. Future Connections Program or it's partners, I DO HEREBY GIVE MY PERMISSION for my child to receive all necessary medical attention if the need arises, including permission for my child to be transported to and seen and/or treated by the nearest hospital in the vicinity of the event. Need shall be determined solely at the discretion of the emergency medical provider and/or the professional staff supervising or coordinating the activity, trip or event.

Initial _____

Parent Signature

REFUSAL OF HEALTH SERVICE
EMERGENCY TREATMENT

If my child should become ill or injured on any field trip sponsored by the University Circle Inc. Future Connections Program or it's partners, I DO NOT HEREBY GIVE MY PERMISSION for my child to receive all necessary medical attention if the need arises, including permission for my child to be transported to and seen and/or treated by the nearest hospital in the vicinity of the event. Need shall be determined solely at the discretion of the emergency medical provider and/or the professional staff supervising or coordinating the activity, trip or event.

Initial _____

Date



Parent Agreement – Activity Consent

As part of the Future Connections Program, student participants may be taken on field trips or visits, and may attend recreational and cultural enrichment activities.

I grant permission for my child to attend and participate in all activities of the Future Connections Program.

I understand that the Future Connections Program and its partners do not carry health and accident insurance and that I am responsible for health incurred costs.

I also grant the Future Connections Program and its agent’s full authority to take whatever action they deem necessary regarding my child’s health and safety in the event of an emergency; and I fully release the Future Connections Program and University Circle Incorporated from any and all liability in connection to those decisions. I understand my child must comply with the Future Connections Program rules and expectations of behavior. I agree that the Future Connections Program and its partners have the right to enforce appropriate standards of conduct, as supplied to students upon enrollment in the program.

Parent Information

Parent Name

Parent Phone Number

Student Information

Name

Date of Birth

Primary Emergency Contact

Emergency Contact Phone

Relationship to Student

Alternate Emergency Contact

Alternate Emergency Contact Phone

Relationship to Student

Please List:

Any Medical Ailments

Allergies

Current Medications

Parent Authorization for Treatment:

In the event of an emergency, I hereby give permission to the event leader selected by the Future Connections Program and it's partners, to take my child to the nearest hospital or clinic, and if necessary, to sign the required documents to secure medical treatment for my child.

This health history is correct to the best of my knowledge, and my child who is named above, has my permission to engage in all program activities as noted by me on this form. By submitting this form, you agree to all above conditions.

Parent Signature
