Florida A&M University
Upward Bound Program
Summer 2010

Summer Packet Checklist (Returning Students)

Student’s Name

- Pick-Up Authorization (Page 1)*
- Health Information (Pages 2-7)
  - Medical Consent/Health Coverage (Pages 2-3)*
  - Medical Contact/Medical Information (Page 4)*
  - Medical Consent & Liability Release (Pages 5-6)*
  - Medical Authorization (Page 7)*
- Rattler Card Application (Page 13)
- FAMU Recreation Center Waiver/Release Forms (Pages 18-20)*

*Requires Parent’s Signature
PARENT/GUARDIAN AUTHORIZATION

Other persons authorized by the parent(s) or guardians(s) to “sign-in” or “sign-out” their child from the program:

PRINTED NAME OF STUDENT ________________________________

Individuals authorized to bring and pick-up the above named student:

<table>
<thead>
<tr>
<th>Name &amp; Address</th>
<th>Phone #</th>
<th>Relationship</th>
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The above listed individual(s) are authorized to bring and “sign-in” or “pick-up”, and “sign-out”

__________________________
Printed name of student

Signed: __________________________
Signature of Parent(s)/Guardian(s)

__________________________
Printed name(s) of parent(s)/guardian(s)

Please provide telephone numbers that can be used to contact parents/guardians in the event of an emergency. Provide daytime and night-time phone numbers.

Daytime Phone Numbers:

Name __________________________ Phone Number __________________________

Name __________________________ Phone Number __________________________

Night-time phone numbers:

Name __________________________ Phone Number __________________________

Name __________________________ Phone Number __________________________
FLORIDA A&M UNIVERSITY
TALLAHASSEE, FLORIDA
TRIO ACADEMIC SUPPORT CENTER
PROJECT UPWARD BOUND

MEDICAL CONSENT FORM

I, ____________________________, parent/guardian of ____________________________
(Parents Name) (Students Name)
by my signature below, grant authority to the staff of Project Upward Bound to refer my child for
preventive, corrective, routine and emergency medical and dental care as needed during the period
he/she is associated with the project since he/she is under 21 years of age.

________________________________________
Signature of Parent/Guardian

________________________________________
Date

________________________________________
Telephone number (home/work)

Sworn to me and Subscribed
Before Me on This Date

________________________________________
(Month) (Day) (Year)

________________________________________
Signature of Notary Public Term Expiration Date

*Does the student have any existing medical conditions of which we should be aware:

_____ Yes  _____ No (if yes, please describe below):

NATURE: ____________________________________________________________

______________________________________________________________

***FORM MUST BE SIGNED BY A PARENT/GUARDIAN***
FLORIDA A&M UNIVERSITY
TALLAHASSEE, FLORIDA
PROJECT UPWARD BOUND

HEALTH INSURANCE COVERAGE QUESTIONNAIRE

Please fill in this Health Insurance Coverage Questionnaire and return it as soon as possible. This will enable us to better serve your child's needs.

1. Do you have any type of health insurance coverage for your child?
   _____ Yes   _____ No

2. If so, answer the following:
   A. Does the insurance cover:
      1. Emergency care   _____ Yes   _____ No
   B. What is the name of the insurance Company?
      
   C. Address of the Company
      ____________________________________________________________________________
      
      (Street)    (City)    (State)    (Zip Code)
      
   D. Policy Number:________________________________________________________________
   E. Effective Date of Policy:_______________________________________________________
   F. Other features of your insurance coverage not described:
      ____________________________________________________________________________
      ____________________________________________________________________________
      ____________________________________________________________________________

(Name of Student – Please Print)__________________________________________________________________________

(Signature of Parent/guardian)__________________________________________________________________________

(Date)__________________________________________________________________________
FLORIDA A&M UNIVERSITY
STATE OF FLORIDA
CONTACT/MEDICAL INFORMATION

Student: __________________________

Social Security#: __________________________ Date of Birth: __________________________

Parent(s)/Guardian(s) Names: __________________________ /

Home Address: ____________________________________________________________

City: __________________________ State: __________________________ Zip Code: __________________________

Home Telephone: (____) __________________________

Parent(s)/Guardian(s) Work Telephone(s)(____) __________________________ (____) __________________________

Another Person to Contact in Case of Emergency: __________________________

Phone Number: (____) __________________________ Relationship: __________________________

******************************INSURANCE INFORMATION******************************

Do you have insurance? Yes ______ No ______

Primary Insurance Company Name: __________________________

Insured's Name: __________________________ Insured's Social Security Number: __________________________

Address: __________________________

City: __________________________ State: __________________________ Zip Code: __________________________

Telephone: (____) __________________________

Policy Number: __________________________ Fax Number: (____) __________________________

Plan Type or Code Number: __________________________

******************************MEDICAL INFORMATION******************************

The following section is to include special allergies or medical conditions that might require special attention during the
UPWARD BOUND PROGRAM. Examples are food, drug or insect allergies, diabetes, chronic illness, recent surgery,
fainting spells, etc. It must also include any hospitalizations for any reason, any regularly prescribed medications, and any
special or psychological examinations, conditions, or treatments.

Allergies: __________________________

Chronic Conditions (Asthma, etc.): __________________________

Regular Medication(s): __________________________

Medical History: ____________________________________________________________

________________________________________ Date: __________________________

Parent(s)/Guardian(s) Signature(s): __________________________
Florida A&M University – Medical Consent and Liability Release

This is a legal and binding agreement which, when signed, will permanently limit your ability to recover from the parties indicated below for injuries or losses you may sustain as a result of participation in Summer Camp or Summer Academic Program activities.

References to Florida A&M University (hereinafter referred to as FAMU) include Florida A&M University, acting by and through its Board of Trustees, the Florida Board of Governors, the State of Florida, its agents, officers, faculty and employees.

PLEASE READ CAREFULLY.

MEDICAL CONSENT FORM

I hereby grant permission for emergency medical service to be rendered as deemed necessary to my child (or myself). I do hereby voluntarily consent and authorize FAMU, in the event of an accident, illness or injury to take whatever measures and actions considered necessary and warranted under the circumstances to protect, safeguard and minimize further injury, health and safety. I understand that such actions may involve or require placement in a hospital or another medical facility for services and treatment. Any transportation expenses by any mode will be a debt and liability for which I accept total responsibility.

I hereby further declare, represent and agree, that in the event that FAMU has to exercise the above voluntarily given medical authorization and consent, that I hold harmless, release and forever discharge FAMU from any and all liability, damages, claims and demands whatsoever, including attorneys fees and court cost, which the undersigned, any heir or assigned has made.

Finally, I hereby declare and represent that I have read this statement, understood its contents, execute it of my free will and choice, and agree to be legally bound by it.

Initial __________ CONTINUE WITH NEXT SECTION
LIABILITY RELEASE

By signing this MEDICAL CONSENT and LIABILITY RELEASE, I assume any and all liability for any accident, injury, damages or loss that may occur during participation or as a result of Summer Camp Activities at FAMU.

In consideration for the acceptance into or voluntary participation in the above stated activity/event, I/We hereby release, waive and discharge any and all demands and claims for, but not limited to, damages, personal injury, property damage, illness, death or loss which I may have or which hereafter accrue to me, against FAMU due to participation in or as a result of the above mentioned activity/event. This release will discharge and hold FAMU harmless from and against any and all liability demands (including attorney fees and court cost) arising out of or connected in any way with participation in or as a result of the above mentioned activity/event, even though that liability may arise out of negligence on the part of persons or agencies mentioned above.
I/We further understand that damages, accidents, injuries or death could arise out of participation or as a result of the above mentioned activity/event. Knowing this, I hereby agree to assume those risks and to release and hold all agencies and persons mentioned above harmless who (through negligence or carelessness) might otherwise be liable to me.
I/We fully understand and agree this disclaimer, release, waiver and assumption of risk, is to be binding on my heirs and assigns.

I HAVE READ THIS ENTIRE RELEASE. I FULLY UNDERSTAND IT AND AGREE TO BE LEGALLY BOUND BY IT.

Print Name of Minor or Participant (if under 18 years old)

Print Name of Parent, Legal Guardian or Custodian

Print Name of Participant (if 18 years or older)

Signature of Parent, Legal Guardian or Custodian

Signature of Participant (if 18 years or older)

Address

Phone Number
FLORIDA AGRICULTURAL AND MECHANICAL UNIVERSITY
STATE OF FLORIDA
MEDICAL AUTHORIZATION

PARENTAL CONSENT & AUTHORIZATION

We/ I understand that our/my son/daughter has been selected to attend the Summer Camp Programs to be held on the campus of Florida Agricultural and Mechanical University (FAMU)

The FAMU Summer Camp Programs accident and sickness insurance coverage is limited to a total amount of $25,000 per accident per participant and $2,500 for sickness per participant. The policy is arranged through FAMU and will be in effect for the duration of the PROGRAM. Upon written request, a copy of the policy will be sent to parents or guardians when it is available. This coverage will be effective from the time the participants register until the dismissal of the camp program, exclusive of time away from the PROGRAM for the holiday weekend or at other times as approved by the Director or the Director's Designee. We/ I understand that my/our health insurance, if available, will be the excess coverage for in the event of accident or illness while attending the PROGRAM. We/ I further understand that in the event we/ I do not have personal accident/medical insurance or have exceeded the camp programs coverage limits, our/ my son/daughter will be financially responsible for the remaining balance of any medical treatment in which he/she receives.

We/ I also authorize the sponsors/administrators of the PROGRAM and authorized representatives of the Insuring Agency to obtain information regarding the medical history, physical condition, and diagnosis of our/my son/daughter as required to document covered accidents/illnesses. A photocopy of this authorization shall be valid as the original. This authorization will be valid for the term of our/my son/daughter’s coverage under the policy.

We/ I, the parent(s) or guardian(s) do hereby request that the FAMU, through its agents or employees, take whatever steps necessary to secure medical treatment for the child named above in the event such child appears to be in need of such treatment while attending the PROGRAM. We/ I consent to the rendering of all necessary treatment including admission to a hospital or other appropriate health care facility, in such institutions and at such places as FAMU summer camp programs, is acting through its agents or employees, deems best. I authorize the agents or employees of the University to execute whatever forms might be necessary to ensure complete and adequate care of our/my child.

We/I affirm that the above medical information is complete and accurate. We understand that pre-existing health conditions are not covered by the FAMU summer camp programs insurance and that such conditions are the financial responsibility of the parent(s) or guardian(s). We/I also understand that the insurance policy cited above does not cover any medical problems known to us/me or that should have been known to us/me and not revealed by us/me to the FAMU summer camp program, and that certain conditions will not be covered under the terms of the insurance policy.

If this document is being signed by only one parent, I, the undersigned, affirm that I have been judicially granted sole custody of the participant. If this document is being signed by a guardian(s), I/we, the undersigned, affirm that I/we have been judicially granted legal guardianship of the participant.

I HAVE READ THIS ENTIRE PARENTAL CONSENT & AUTHORIZATION. I FULLY UNDERSTAND IT AND AGREE TO BE LEGALLY BOUND BY IT.

Name of Summer Camp Program

Print Name of Minor Participant

Print Name of Parent(s), Legal Guardian or Custodian

Signature of Parent, Legal Guardian, Custodian or Participant if 18 years or older

Program Start Date / Program End Date

Participant’s Date of Birth

Date

Date
Florida A&M University
Summer Programs
Application for FAMU Rattler Card

Date __________________________

Name __________________________

SS# ____________________________ Student ID# __________________________
(For FAMU Students)

Name of Program __________________________

Your Florida A&M University ID card, known as the Rattler Card is non-transferable. It should be carried with you at all times and presented upon request to any University official. This card and its use are governed by Florida A&M University Rules and Regulations.

If you choose to use the Rattler Card vending system, you should be aware that the only accounting of vending money resides on the magnetic strip. If your card is lost or stolen, or if the magnetic strip is damaged, you will lose any remaining monies. Cardholder is urged to restrict his/her available dollar value to not exceed $20.00.

Lost or stolen Rattler Cards should be reported to the Rattler Card Office in the Student Services Center, Room 4, or by calling 599-VENM (8366).

I, ____________________________, have read, understand and agree to these conditions.

Signature
FAMU Recreation Center

1. Physical Activity Readiness Questionnaire – PAR-Q
   Common sense is your best guide when you answer these questions. Please, read the questions carefully and answer each one honestly: check YES or NO.

   YES  NO
   □  □ Are you a male ≥ 40-years-old or a female ≥ 50-years-old
   □  □ Do you feel pain in your chest when you do physical activity?
   □  □ Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
   □  □ In the past month, have you had chest pain when you were not doing physical activity?
   □  □ Do you lose your balance because of dizziness or do you ever lose consciousness?
   □  □ Do you have a bone or joint problem that could be made worse by a change in your physical activity?
   □  □ Is your doctor currently prescribing drugs (e.g., water pills) for your blood pressure or heart condition?
   □  □ Do you know of any other reason why you should not do physical activity?

   *** If you answered YES to one or more questions, clients must seek physician clearance prior to working with a trainer. Talk with your doctor BEFORE you start becoming much more physically active. Tell your doctor about the PAR-Q and which questions you answered YES.

   If in doubt after completing this questionnaire, consult your doctor prior to physical activity.

2. Risk Factor Identification (check all that apply)
   □ Family History
     55-year-old – Father or immediate male family member with heart attack or sudden death.
     65-year-old – Mother or immediate female relative with heart attack or sudden death
   □ Current Cigarette Smoking
   □ Hypertension
     Blood pressure > 140/90 mmHg confirmed on two separate occasions
     Currently taking hypertensive medications
   □ Hypercholesterolemia
     Total serum cholesterol > 200 mg/dl, or HDL < 35 mg/dl, or LDL > 130 mg/dl
   □ Impaired Glucose Fasting
     Fasting Glucose ≥ 110 mg/dl confirmed by measurements on two separate occasions
   □ Obesity
     Body Fat: Male > 25% or Female > 32%
   □ Sedentary Lifestyle
     No regular physical activities
     No active recreational pursuits
     Inactive job (majority of time is spent sitting)

   Total Risk Factors ______

   All clients with 2 or more risk factors should be evaluated by a physician prior to engaging in physical activity.

   I have read, understood, and completed this questionnaire. Any questions I had were answered to my full satisfaction.

   Participant Name (Print) ________________________________ Date_______
   ______________________________________________________ Date_______
   ________________________________ Date_______

   Signature
   ______________________________________________________ Date_______
   ________________________________ Date_______

   Signature of Parent or Guardian (for participants under the age of 18)
Physician’s Statement and Clearance Form

At the FAMU Recreation Center, your safety is our primary concern. For that reason, we comply with the health and fitness standards of the American College of Sports Medicine and the International Health, Racquet and Sportsclub Association.

On the Health History Questionnaire you just completed, you identified that you have one or more coronary and/or medical risk factors which may impair your ability to exercise safely. For this reason, you need to have a physician complete and return this medical clearance form before you can begin exercising at the FAMU Recreation Center.

We recognize that you are eager to start your fitness program, and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your exercise experience to be as safe and rewarding as possible.

In order to expedite this process, we will gladly fax this form directly to the physician of your choice. If the physician is aware of your medical history, he/she may be able to complete this form and have it ready for you to pick-up. For confidentiality reasons, we ask that these forms not be faxed back to the FAMU Recreation Center with your health history indicated on them. Please, bring these forms in personally.

I hereby give my physician permission to release any pertinent medical information from any medical records to the staff at the FAMU Recreation Center. All information will be kept confidential.

Patient’s Name (Print): ____________________________ Date: ____________________________
Patient’s Signature: ____________________________
Reason for medical clearance: ____________________________
Physician’s name: ____________________________
Address: ____________________________
Phone: ____________________________ Fax: ____________________________
Trainer’s Name: ____________________________

For Physician Use Only

Please, check one of the following statements:

____ I concur with my patient’s participation in an exercise program or exercise testing with no restrictions.

____ I concur with my patient’s participation in an exercise program or exercise testing if he/she restricts the activities to:

__________________________________________________________

Maximum Heart Rate not to be exceeded: _______ BPM

____ I do not concur with my patient’s participation in an exercise program or exercise testing. (If checked, participant will not be able to join the Recreation Center)

Reason: ___________________________________________________________

Physician’s Name: ____________________________
Physician’s Signature: ____________________________ Date: ____________________________
FAMU Recreation Center
Waiver and Release of Liability

1. In consideration of my participation in a program of strength, flexibility and cardiovascular training, I hereby release and covenant not-to-sue Florida A&M University, The State of Florida Board of Governors, FAMU Board of Trustees, The FAMU Recreation Center, and any of their employees, or agents from any and all present and future claims resulting from ordinary negligence on the part of Florida A&M University or others listed for property damage, personal injury, or wrongful death, arising as a result of my participation in or receiving instruction in physical exercise. I hereby voluntarily waive any and all claims resulting from ordinary negligence, both present and future, that may be made by me, my family, estate, heirs, or assigns. (Please Initial: __________)

2. Further, I am aware that strength, flexibility and cardiovascular exercise, including the use of equipment, is a potentially hazardous activity. I am aware and understand that fitness activities involve certain risks, including but not limited to, death, serious neck and spinal injuries resulting in complete or partial paralysis, heart attack, serious disability, and serious injury to all bones, joints and muscles and that I am voluntarily participating in these activities and using equipment and machines with full knowledge, understanding and appreciation of the dangers involved. I hereby agree to accept any and all inherent risks of injury or death. (Please Initial: __________)

3. I do hereby further declare myself to be physically fit and suffering from no condition, impairment, disease, infirmity or other illness that would prevent my participation or use of equipment or machines. I acknowledge that I have either had a physical examination and have been given permission by my physician to participate, or I have decided to participate in the exercise activities, programs and use of equipment without the approval of my physician in said activities, programs and use of equipment. (Please Initial: __________)

4. I further agree to indemnify and hold harmless The Florida A&M University and others listed for any and all claims arising as a result of my participation in or receiving instruction in strength, flexibility and cardiovascular activities or any activities incidental thereto, wherever, whenever, or however the same may occur. (Please Initial: __________)

5. I understand that this waiver is intended to be as broad and inclusive as permitted by the laws of Florida and agree that if any portion is held invalid, the remainder of the waiver will continue in full legal force and effect. I further agree that the venue for any legal proceedings shall be in the state of Florida. (Please Initial: __________)

6. I affirm that I am of legal age and am freely signing this agreement. I have read this form and fully understand that by signing this form, I am giving up legal rights and / or remedies which may be available to me for the ordinary negligence of The Florida A&M University or any of the parties listed above. (Please Initial: __________)

________________________________________________________________________
(Participant Name)

________________________________________________________________________
(Signature of Participant)

________________________________________________________________________
(Date)

________________________________________________________________________
(Parent/Guardian Name if Participant is under 18)

________________________________________________________________________
(Signature of Parent/Guardian if Participant is under 18)

________________________________________________________________________
(Date)