AUTHORIZATION FOR PURPOSES OF PROVIDING MEDICAL TREATMENT
GREAT LAKES SPACE PORT EDUCATION FOUNDATION, INC. /ROCKETS FOR SCHOOLS

Sheboygan, Wisconsin

I,___________________________________, hereby grant _______________________________________ permission to attend Great Lakes Space Port Education Foundation, Inc./ Rockets for Schools events held from May 7, 2010 thru May 8, 2010.

Furthermore, in the case of an accident, I will not hold Great Lakes Space Port Education Foundation, Inc. / Rockets for Schools, the Sheboygan Area School District, and Tripoli Rocket Association, The City of Sheboygan or other participating organizations responsible for damages incurred. I do hereby authorize Great Lakes Space Port Education Foundation, Inc. /Rockets for Schools, the Sheboygan Area School District, Tripoli Rocket Association and the City of Sheboygan or other participating agencies to incur medical costs necessary to provide treatment for said child, for which we shall be fully responsible. We also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

I understand that participants are sometimes photographed and/or video taped for use in R4S promotional and education materials and I am giving my permission to do this. CIRCLE ONE: YES NO

____________________________________ ____________________________________

(Parent/Guardian Signature) Date

Please Print Clearly

Rockets for Schools Participant Name __________________________________ Birthdate _____________

Address ____________________________________ Physician______________________________

____ Address ______________________________

Phone ( ) __________________________________ Phone ( ) ___________________________

Participant's School ____

Who to reach in case of an emergency?

Name ______________________________________ Phone ( )___________________________

Name ______________________________________ Phone ( )___________________________

INFORMATION NEEDED ABOUT PARTICIPANT:	YES	NO	If yes, Indicate below
IS there any chronic problem or illness?	_____	_____	______________________
IS there any acute illness now present?	_____	_____	______________________
HAS the person been treated recently for any medical problem?	_____	_____	______________________
LIST any medications now being taken for treatment of any medical problem	_____	_____	______________________
ARE there any allergies to medication or local anesthetics?	_____	_____	______________________
Are there any allergies?	_____	_____	______________________

DATE of last Tetanus shot ____________________________________

INSURANCE INFORMATION:

Policyholder's Name and Relationship to Patient ____

Policy Holder's Address ____

Name and Address of Insurance Company ____

Name and Address of Employer ____

Business Phone Number ( ) __________________________

ALL Policy numbers (Please Identify) ____

NOTE: FORM MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN BEFORE YOUTH CAN PARTICIPATE IN ROCKETS FOR SCHOOLS ACTIVITIES