

**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 9, 2008 thru May 10, 2008.

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