Duke TIP – Participant's Release Form

Continuing Education
ATTN: Gina Cregg
1515 Saint Andrews Drive
Lawrence, Kansas 66047

(Please complete forms, including required signatures and fax or mail prior to the weekend.)

Student:_____ Date of Birth: Mo:____ Day:____ Yr:_____

Name of Parent or Guardian: _____

_____

(street address) (city / state) (zip)

Parent/Guardian e-mail Address:_____ Home Telephone:_____

Work Telephone: _____

The above-named student, and the parent or legal guardian of the above-named student, in consideration of the sponsorship of THE UNIVERSITY OF KANSAS and DUKE UNIVERSITY, the consideration paid by us for, and the right to participate in, the event or program described as the DUKE UNIVERSITY TALENT IDENTIFICATION PROGRAM'S SCHOLAR WEEKEND PROGRAM, do hereby agree to the following related to Duke TIP.

First, that the student, as a participant in a Duke University TIP program, pledges to conduct himself/herself in a manner that reflects favorably upon all concerned. Students are bound to the conduct guidelines stipulated in the Rules and Regulations form for Scholar Weekends. Staff of the Duke TIP Scholar Weekend Program may discipline a student or refer a student to the Director of Educational Programs for dismissal from the program for behavior detrimental to the program or not in keeping with the program guidelines provided to parents and students. Should a student be dismissed for academic reasons resulting from the student's lack of effort or attitude toward the academic environment, no fees will be returned to student or parents.

We further agree that Duke TIP reserves the right to make cancellations, changes, and substitutions in case of emergency or changed conditions, or if such are in the best interests of the group affected. Should Duke TIP cancel a program, full refunds of the program fees will be made unless the cancellation is due to causes outside the control of Duke TIP, in which case Duke TIP will refund *only uncommitted and recoverable funds*. In addition, it is agreed that the cost of travel to and from the program is not included in any fees that may be refunded.

It is also agreed that should a student leave the program for any reason other than a death in the immediate family or an illness which requires hospitalization, after the fee deadline set by Duke TIP (see application) has passed, there will be *no refund* of any fees. Should the student leave a program as the result of death in the immediate family or an illness that requires hospitalization, Duke TIP will refund *only uncommitted and recoverable funds which will be prorated before return*.

PARTICIPANT NAME: _____

The above-named student, and the parent or legal guardian of the above-named student who is under the age of 18, as a participant in the Duke TIP, does hereby acknowledge, agree, promise, and covenant with THE UNIVERSITY OF KANSAS and DUKE UNIVERSITY and its trustees, officers, employees, agents, and all other persons or entities, and do hereby release, hold harmless and discharge THE UNIVERSITY OF KANSAS and DUKE UNIVERSITY and its trustees, officers, employees, agents, and all other persons or entities involved in Duke TIP from any and all liability for any injury, death, illness, disease and damage to said student or damage to said student's property which might be sustained while participating in Duke TIP, including but not limited to residential living and travel incidental to Duke TIP, and I execute this release on behalf of and with the specific intent to legally bind myself, my heirs, assigns, personal representative and state.

I hereby certify that I have no medical conditions that will prevent my normal participation in the subject event or program. I further understand and acknowledge that no medical insurance benefits will be provided to me during this event, and I certify that I have sufficient health, accident and liability insurance to cover any bodily injury or property damage I may incur while participating in this event and to cover bodily injury or property damage caused to a third party as a result of participation in this event.

PARTICIPANT'S RELEASE AND AGREEMENT

Participant Name (printed): _____

My signature below indicates that I have read this entire two-page document, understand it completely, and agree to be bound by its terms.

Note: Both Participant and Parent/Guardian must sign.

SIGNATURE OF PARTICIPANT: _____

Date Executed: _____

SIGNATURE OF PARENT OR GUARDIAN: _____

Date Executed: _____

Please make a copy of forms for your records

We must receive a copy of the release forms by March 3.

Please mail or fax a completed, signed form to:
KUCE Duke TIP, 1515 St. Andrews Drive,
Lawrence, KS 66047

or fax: (785) 864-4871

University of Kansas Continuing Education

Duke TIP Scholar Weekends MEDICAL Release Form

The parent/guardian of the participating student must complete all items on this form. It is critical that we be fully informed about all the participant's medical needs. KU & Duke TIP staff and medical personnel will refer to this form whenever medical treatment is necessary and will treat information provided with the greatest possible confidentiality. Please respond to all questions. **A Medical Release form must be completed for each Duke TIP Scholar weekend participant. Returning students must complete a new medical form each year**.

STUDENT INFORMATION

TIP ID#:_____ Student's Name:_____

Date of Birth: _____ Gender: _____

Home Phone #: (_____)_____ Scholar Weekend Dates: _____

Parent/Guardian Name (s): _____

Permanent Address: _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first:	Backup contact:
Name:_____	Name:_____
Relationship to student: _____	Relationship to student: _____
Daytime Phone #: (_____)_____	Daytime Phone #: (_____)_____
Evening Phone #: (_____)_____	Evening Phone #: (_____)_____

INSURANCE POLICY INFORMATION

The above named child is covered by health insurance. ☐ yes ☐ no

- **IF YES**, provide the following information required by health providers to expedite treatment and to facilitate billing process.

Policy Holder's (P.H.) Name: _____ P.H.'s Date of Birth: _____

Address: _____ Relationship to Student: _____

City, State, Zip: _____ Occupation: _____

P.H.'s Employer's Name: _____

Employer's Address: _____

Insurance Company's

Name: _____ Address: _____

Phone: (_____)_____ Policy #: _____ Plan: _____

Specific Instructions regarding insurance: _____

_____

- **IF NO**, please be aware the Duke TIP cannot admit ANY student to a Scholar Weekend without proper health insurance. If you would like to apply for short term health coverage with Assurant Health, please visit their website at www.assuranthealth.com, click on "Health Plans" and then click on 'Short Term' underneath 'Individual Plans' category. You will be able to apply for coverage online at that site. Please note that if you elect to pay by check, you must print out the application and mail it to Assurant Health along with your check made payable to Assurant Health. If you have any questions, you may call Assurant Health plans at 866-884-INFO (866-884-4636).

Please indicate below how you plan to secure health insurance.

☐ I plan to purchase insurance through the above agency and will mail or fax coverage verification to Duke TIP before the Scholar Weekend.

☐ I will purchase insurance through another source and will mail or fax coverage verification to Duke TIP before the Scholar Weekend.

MEDICAL CONDITIONS

Does the student currently have any of the following conditions? (If yes, please describe)

		Medications Taken
Drug allergies:	☐ NO ☐ YES_____	_____
Food allergies:	☐ NO ☐ YES_____	_____
Allergies to insect bites:	☐ NO ☐ YES_____	_____
Special dietary needs:	☐ NO ☐ YES_____	_____
Asthma:	☐ NO ☐ YES What is the trigger?_____	_____
Frequent headaches:	☐ NO ☐ YES_____	_____
Dizziness or seizures:	☐ NO ☐ YES_____	_____
Physical restrictions:	☐ NO ☐ YES_____	_____
Serious eye defects:	☐ NO ☐ YES_____	_____
Frequent ear infections:	☐ NO ☐ YES_____	_____
Hearing defects:	☐ NO ☐ YES_____	_____
Bronchitis:	☐ NO ☐ YES_____	_____

Other(s):_____

1) Has the student had psychological counseling? ☐ NO ☐ YES; if yes, please explain_____

_____

2) Please list any other medications the student has been prescribed and explain why it has been prescribed._____

_____

ACCEPTANCE OF DUKE TIP MEDICATION POLICY

Parents and students are asked to read the following statement carefully and sign to signify your understanding of the medication policies for both prescription and non-prescription drugs. Your signatures further indicate that you and your child agree to abide by Duke TIP policies regarding medication.

I understand that neither the University of Kansas, Duke University, nor their Talent Identification Program (TIP) can in any way assume responsibility for dispensing my child's medication to her/him nor can the University of Kansas, Duke University, or their TIP program assure that my child has taken his/her medication. I further understand that it is my child's responsibility to self-medicate. I also understand that within a policy of limited confidentiality, some staff members may have access to my child's medication information. However, I also understand that this access is needed for administrative purposes and not for the monitoring of student medication issues by staff.

If you as a parent or legal guardian do not believe that your child can assume full responsibility for her/his medication needs, then the Duke University Talent Identification Program's Scholar Weekend may not be the appropriate program for your child. Your signature and that of your child on the lines below indicate that you and your child agree to comply with the Duke TIP policy on medication.

SIGNATURE OF PARENT OR LEGAL GUARDIAN_____ DATE_____

I understand that my signature below indicates that I am assuming responsibility for abiding by all of Duke TIP's medication policies; storing all medication, prescription as well as non-prescription, in a secure location; maintaining the medication schedule prescribed by my doctor(s) for taking my medication(s), and meeting my own medication needs.

SIGNATURE OF DUKE TIP STUDENT _____ DATE_____

FULL DISCLOSURE OF MEDICAL INFORMATION

I affirm that I have provided the University of Kansas and Duke University TIP with full disclosure of information related to my child's physical and psychological health.

_____ _____

Parent/Legal Guardian Signature **Date**

In the event I cannot be reached to give my consent, I, legal guardian of _____, a minor authorize KU-Duke University Talent Identification Program staff to seek medical treatment as they deem necessary at a local medical center or health care facility while my child is attending Duke TIP Scholar Weekend Programs. I consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary or advisable by a licensed health care provider during the session. I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care, and that it is given to provide the Duke University Talent Identification Program staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as he/she judges necessary to the above-named student. I understand it is not the responsibility of Duke University staff to file insurance claims. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Duke University TIP staff will make a good faith effort to contact me before seeking treatment. If this is not possible, I understand that the Duke University TIP staff will notify my designee or me as soon as possible of any and all diagnoses and treatments. Neither the University of Kansas, Duke University TIP, nor its Scholar Weekend Program staff can be responsible for paying for prescription medication.

_____ _____

Parent/Legal Guardian Signature **Date**

_____

Printed Name of Parent or Legal Guardian

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