

## ENTREPRENEURIAL CODE CAMP STUDENT INFORMATION FORM

Participant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Spring 2017 Grade: \_\_\_\_\_

School Name: \_\_\_\_\_

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### EMERGENCY CONTACT(S):

1. Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

2. Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### PERSON(S) AUTHORIZED TO PICK STUDENT UP DAILY FROM CAMP *(if applicable)*:

1. Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

2. Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

A student will not be released to anyone not authorized in this form. Proper form of identification will be required to release a child for pick up to other person(s) than parent(s) or guardian(s). To deviate from this form once the program is in session, a written, well documented and signed letter from the parent(s) or guardian(s) will be required. The program personnel will not release any student to anyone without proper authorization from the parent(s) or guardian(s) and without proper identification. Please, make sure you abide to this rule. There will be NO exceptions.

\_\_\_\_\_

PARENT/LEGAL GUARDIAN SIGNATURE

DATE

## ENTREPRENEURIAL CODE CAMP STUDENT INFORMATION FORM (CONT.)

### MEDICAL INFORMATION FORM

1. Does your child have any special dietary needs? *(Circle one)* YES NO

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Does your child have any allergies? *(Circle one)* YES NO

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Does your child have any medical conditions or health problems of which we should be aware of? *(Circle one)* YES NO

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Will your child need to take any prescribed medication(s) or OTC medication(s) during the hours of the summer program? *(Circle one)* YES NO

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. In case of an emergency, we will take your child to Holmes Regional Medical Center – the nearest hospital to Florida Institute of Technology. Please provide the following insurance information:

Insurance Company: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Phone: \_\_\_\_\_

I/We the undersigned, as parent(s) or guardian(s), authorize Florida Institute of Technology to transport and to obtain at our expense, through a physician of its own choice, any emergency medical care that may become reasonably necessary for the student identified herein, through the course of the summer program.

PARENT/LEGAL GUARDIAN SIGNATURE

DATE