

# Marine Biological Laboratory



## **PARENTAL PERMISSION, EMERGENCY CONTACT, AND MEDICAL INFORMATION**

### **PARENTAL PERMISSION**

Individuals under the age of 18 must have parent/legal guardian permission to participate in [Name of Program], (hereafter, the Program). The parent/legal guardian MUST read and complete all sections of this form.

For questions, contact Jean Enright, High School Science Discovery Program Student Life Coordinator at [jenright@mbi.edu](mailto:jenright@mbi.edu) or 508-289-7674.

I certify that I am the parent or the legal guardian of \_\_\_\_\_ (child/ward) and that s/he has my permission to participate in activities during the Program at the Marine Biological Laboratory (MBL). I understand that s/he will participate in classroom and/or laboratory research activities, in course and/or research related activities outside of the classroom or laboratory, and in extracurricular events on and off the MBL campus. I understand that MBL rules will apply and that, if my child/ward violates these rules, as determined by MBL, MBL reserves the right to discontinue his/her participation in the program.

I understand that my child/ward may be photographed and/or video recorded in relation to MBL research, activities, and events for non-commercial purposes and further agree that MBL has the right to publish, adapt, exhibit, distribute, display or otherwise use or re-use any such photographs or video recordings in connection with or for non-commercial publications by the MBL, in any medium, whether now known or hereafter existing, and for other non-commercial purposes of the MBL.

### **MEDICAL CERTIFICATION, INFORMATION AND CONSENT FOR MEDICAL TREATMENT**

I certify that my child/ward has no medical condition, allergy or other special dietary need that might subject him/her to injury as a result of his/her participation in the Program.

I understand that the MBL does not provide medical insurance to my child/ward. I certify that I have adequate medical insurance to pay for any medical services that may be required while s/he is participating in the Program. I have provided all the necessary medical insurance information on the attached Medical Information Sheet.

In the event that my child/ward requires medical care, including surgery or administration of drugs, blood or anesthetic and I cannot be reached or the emergent circumstances do not allow a member of the MBL administrative staff time to reach me, I authorize a member of the MBL administrative staff to obtain for my child/ward such medical services as deemed necessary. I understand and agree that the MBL and its employees shall have no liability for any injury or damage that might arise out of or in connection with such authorized emergency medical treatment.

**WAIVER AND RELEASE**

I acknowledge that my child's/ward's participation in the Program is voluntary. In consideration of my child/ward being permitted to participate in the Program, I agree to assume all risks and responsibilities surrounding my child's/ward's participation in the Program, transportation to and from the Program, and hereby release, waive, forever discharge the MBL, the University of Chicago, and each of their respective trustees, officers, agents, and employees from and against any and all liability for any harm, injury, damage, claims, demands, actions, causes of action, costs and expenses of any nature which I, my spouse or my child/ward may have, arising out of or related to any loss, damage, or injury, including but not limited to death, that may be sustained by my child/ward or by any property belonging to him/her, except to the extent caused by the sole negligence of the MBL.

I have signed this Waiver and Release in full recognition and appreciation of the dangers, hazards, and risks of the Program. In signing this Release, I acknowledge and represent that I have fully informed myself of the content of this Release, that I have reviewed it and understand what it means, and that I sign this document freely. No oral representations, statements, or inducements, apart from the foregoing written statement, have been made. I understand that the MBL does not require my child/ward to participate in this Program, but I want him/her to do so, despite the possible dangers and risks and despite this Release.

I further agree that this Release shall be construed in accordance with the laws of the Commonwealth of Massachusetts. If any term or provision of this Release shall be held illegal, unenforceable, or in conflict with any law governing this Release, the remaining portions shall not be affected thereby. This release shall be binding upon me, my child/ward, our respective heirs, legal representatives, and assigns.

By my signature below, I represent and warrant that I am the parent or legally appointed guardian of the below named minor participant and that I have the legal right to contract for him/her in the above regard.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent or Legal Guardian

\_\_\_\_\_  
Printed Name of Minor Participant

**EMERGENCY CONTACT INFORMATION**

**In the case of an emergency, we must be able to contact you as quickly as possible. It is essential that this form have accurate and complete information. Please provide information for three adults, including at least one parent or guardian.**

1. Name \_\_\_\_\_  
Home Address \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Work Schedule \_\_\_\_\_  
Other Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Relation to Participant \_\_\_\_\_

2. Name \_\_\_\_\_  
Home Address \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Work Schedule \_\_\_\_\_  
Other Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Relation to Participant \_\_\_\_\_

3. Name \_\_\_\_\_  
Home Address \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Work Schedule \_\_\_\_\_  
Other Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Relation to Participant \_\_\_\_\_

**MEDICAL INFORMATION SHEET**

**The following information will be vitally important in the unfortunate event of a medical emergency, particularly if it occurs during a field trip off-campus. Please fill out this form completely and accurately.**

Name of Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Insurance Company Phone # \_\_\_\_\_

Employer or Group Name \_\_\_\_\_

Group Number \_\_\_\_\_

Policy Number \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Relationship of Policy Holder to Student \_\_\_\_\_

Does your insurance require you to contact the insurer or primary care physician or other person to approve medical treatment to assure insurance coverage for the medical bills? \_\_\_\_ Yes \_\_\_\_ No

If Yes, please provide the following:

Person to contact \_\_\_\_\_

Phone Number \_\_\_\_\_

**Please note that the MBL will endeavor to contact the necessary individual to approve medical treatment but is not liable if such contact cannot be made.**

Please provide any other information that may be helpful in helping your claim against your insurance company for any medical bills your child/ward incurs:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_