Authorization of Use

☐ General Use

☐ Specific Project: Markey Cancer Center ACTION Program

I, (print full name) _____ (*) hereby grant permission to the University of Kentucky and its affiliates and subsidiaries, including but not limited to the UK Alumni Association, UK Athletics Association and UK Research Foundation, to interview, photograph and/or videotape me, or my minor child, and/or to supervise any others who may do the interview, photography and/or videotaping and/or to use and/or permit others to use information from the aforementioned interview and/or the aforementioned images in educational and promotional activities for the following without compensation:

- ✓ University Educational Publications/Videos
- ✓ University Electronics Publishing (e.g. World Wide Web)
- ✓ Any University Social Media Initiatives
- ✓ University Promotion/Advertising
- ✓ Local/regional/national news media (w/permission of the University of Kentucky)

Signature: _____ Date: _____
Signature

Witness: _____ Date: _____
Signature

Name and mailing address (please print)

Name: _____

Address: _____

_____

Email: _____

Phone: _____

***If the individual to be interviewed, photographed and/or videotaped is under the age of 18, please indicate your relationship or authority to consent: _____**

Signature of Parent or Guardian: _____ Date: _____

ACTION Summer Program
Transportation Permission Form

I, _____, agree to have UK ACTION staff or other qualified
(Parent/Guardian Full Name)
individuals transport my son/daughter _____ to locations away
(Student Full Name)
from the University of Kentucky, Lexington.

It is my understanding that field trips of a cultural, educational or recreational nature will be taken during the period of the program and that attendance on these trips constitutes an important part of the overall ACTION Summer Program experience.

_____ _____

Parent/Guardian Signature Date

CONTRACT FOR OFF CAMPUS TIRPS

ACTION SUMMER PROGRAM

The following statements must be read and signed by each ACTION Program student and his or her parent or legal guardian. Students who do not sign, or whose parents will not sign, will not be allowed to join us on the trip(s).

I,_____understand the following rules and regulations governing ACTION trips to off-campus locations.

1. There will be no alcohol in my possession.
2. There will be no illegal drugs in my possession.
3. There will be no tobacco products or smoking products in my possession.
4. I will comply with all ACTION Program rules and policies and will adhere to all scheduled activities (I will not be late!).
5. As a representative of the ACTION Program I understand that I represent the program to all who see me and will conduct myself as a lady or gentleman at all times. I will treat all students and staff with respect.
6. I will abide by staff requests and remember safety is important.

If I know that any of the above rules are being broken by other ACTION students and do not report it to a staff member, I am just as guilty as the person breaking the rule and will accept the same consequences. **I understand that if I break any of these rules that my parent/guardian will be called immediately and that I will be sent home at their expense.**

Participant Signature_____ Date_____

I am the parent or legal guardian of the above-signed student and I understand that if my son or daughter breaks any of the rules listed above that I will be responsible for the expense of sending him or her home immediately.

Parent/Legal Guardian Signature_____ Date_____

Markey Cancer Center ACTION Program
University of Kentucky
PERMISSION TO LEAVE CAMPUS

Parents/legal guardians are the only authorized individuals allowed to pick up students during the week (please refer to the attendance policy). However, we do understand that there may be times when some parents/guardians need to authorize another individual to pick up a student on Friday afternoon to transport them home for the weekend.

Please list those individuals who have permission to pick up your son/daughter on Friday afternoons while they are participating in the ACTION summer program.

Student Name: _____

Custodial Parent(s)/Guardian(s):
_____/_____
Mother & Phone Number Father & Phone Number
(If more than one parent/guardian, please list BOTH names)

My son/daughter has permission to leave campus with the following:

Name/Relationship to Student	Phone Number
Example: Joe Smith (Uncle)	859-123-4567

My son/daughter *MAY NOT* leave campus with the following individual(s):_____

_____

_____ _____
Parent/Guardian Signature Date

UNIVERSITY OF KENTUCKY

EXCESS INSURANCE FOR CAMPS/CONFERENCES/FIELD TRIPS

Insurance Coverage	Insurance coverage is on an **excess** basis only. The participants' personal health insurance will be primary and provide coverage for accident and sickness. The **excess** policy will cover any out-of-pocket expense not paid by the participants' personal insurance up to the limits of the policy listed below. (This includes payment of the deductible and coinsurance amounts if applied under the participants' personal policy.) The sickness medical expense will be limited to $500 on an **excess** basis. The benefit period is one year. The first expense must be incurred within 60 days of the accident or sickness. If the participant does not have personal health insurance coverage, this **excess** policy will pay first dollar, up to the limits of the policy. Pre-existing conditions are not covered. A pre-existing condition is any condition for which a prudent person should have sought treatment or was treated in the previous six months.
Coverage Benefits & Limits	Accident Medical Expense (**Excess**) $50,000 Accident Dental Expense (**Excess**) Included Deductible Nil Sickness Medical Expense (**Excess**) $500 Deductible Nil AD&D and Paralysis, Principal Sum $15,000 Benefit Period One Year Effective Date 1/1/16

Consent to Medical Treatment/Insurance Statement

It is understood that authority is given to the University of Kentucky, or anyone they may designate, to have my son/daughter treated for injuries or illnesses they incur during a designated camp, conference, or field trip activity at the University of Kentucky.

I understand that I will be notified if a health problem arises, but in the event I cannot be reached by telephone, I hereby give the University of Kentucky, or anyone they may designate, permission to seek medical treatment for the participant named below, including surgery (on an emergency basis) or additional advanced treatments (MRI, lab tests, etc.) as deemed necessary by competent medical personnel.

I am aware that, as the adult participant, or as the parent or legal guardian of the participant named below, I will be responsible for any expenses incurred outside of the limits provided by the University of Kentucky's Camps/ Conference/Field Trip Policy. I also understand that the University of Kentucky insurance coverage is on an "excess" basis only. The excess policy will cover any out-of-pocket expense not paid by the participant's personal insurance up to the limits of the policy listed above.

_____ _____ _____

Date Name of participant Signature (Parent or Guardian if claimant is a minor)

Emergency Contact (If other than parent)

Name: _____ Relationship: _____

Phone Number: (home) _____ (work) _____

University of Kentucky
Minors Participating in a Program/Camp Informed Consent, Voluntary Waiver, Release of Liability & Assumption of Risks Form

PROGRAM/CAMP INFORMATION:

Program/Camp Name: ACTION Summer Program

Date(s): 5/30/2020-7/2/2020 **Time(s):** _____

Location: University of Kentucky

PARTICIPANT INFORMATION:

Name of Participant: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Date of Birth:** _____ **Gender:** M _____ F _____

PLEASE READ THIS DOCUMENT CAREFULLY BEFORE SIGNING. THIS IS A LEGALLY BINDING DOCUMENT. THIS FULLY SIGNED FORM MUST BE SUBMITTED BY A PARENT OR LEGAL GUARDIAN BEFORE ANY CHILD IS ALLOWED TO PARTICIPATE IN THE ABOVE REFERENCED PROGRAM/CAMP.

I, the undersigned, wish for my Child (hereafter "Child") to participate in the above referenced youth program (hereafter "Program") on the date(s) and location(s) indicated above and, in consideration for my Child's participation, I hereby agree as follows:

I acknowledge, understand and appreciate that as part of my Child's participation in the Program there are dangers, hazards and inherent risks to which my Child may be exposed, including the risk of serious physical injury, temporary or permanent disability, and death, as well as economic and property loss. I further realize that participating in the youth program may involve risks and dangers, both known and unknown, and have elected to allow my Child to take part in the Program. Therefore I, on behalf of my Child, voluntarily accept and assume all risk of injury, loss of life or damage to property arising out of training, preparing, participating and traveling to or from the Program.

I, on behalf of my Child, hereby release the University of Kentucky, its Board of Trustees, Administration, Faculty, Staff, Student Leaders, the Program Staff, and all other officers, directors, employees, volunteers and agents (hereafter "UK") from any and all liability as to any right of action that may accrue to my heirs or representatives for any injury to my Child or loss that my Child may suffer while training, preparing, participating and/or traveling to or from the Camp. This agreement is binding on my heirs and assigns.

I, on behalf of my Child, furthermore release, indemnify and hold harmless UK from and against any and all liability, actions, debts, claims and demands of every kind whatsoever, specifically including, but not limited to, any claim for negligence or negligent acts or omissions and any present or future claim, loss or liability for injury to person or property that my Child may suffer, for which my Child may be liable to any other person, that may or does arise out of my Child's participation in the Program. I understand that UK accepts no responsibility for my Child's personal property.

In the event of an accident or serious illness, I hereby authorize representatives of UK to obtain medical treatment for my Child on my behalf. I hereby hold harmless and agree to indemnify UK from any claims, causes of action, damages and/or liabilities, arising out of or resulting from said medical treatment. I further agree to accept full responsibility for any and all expenses, including medical expenses that may derive from any injuries to my Child that may occur during his/her participation in the Program.

This RELEASE contains the entire agreement between the parties to this agreement and the terms of this RELEASE are contractual and not a mere recital. The information I have provided is disclosed accurately and truthfully. I have been given ample opportunity to read this document and I understand and agree to all of its terms and conditions. I understand that I am giving up substantial rights (including my right to sue), and acknowledge that I am signing this document freely and voluntarily, and intend by my signature to provide a complete and unconditional release of all liability to the greatest extent allowed by law. My signature on this document is intended to bind not only myself and my Child but also the successors, heirs, representatives, administrators, and assigns of myself and my Child.

Participant Name _____ **Parent/Guardian Name** _____

Participant Signature _____ **Parent/Guardian Signature** _____

Date _____ **Date** _____

A PARENT OR GUARDIAN MUST SIGN THIS FORM FOR A MINOR UNDER THE AGE OF 18

University of Kentucky
ACTION Summer Program
STUDENT MEDICAL DATA

Student's Name
(**please print**):_____Date of Birth: _____ Sex: M___F___

Address: _____
Street or Route City State ZIP

High School:_____ Social Security Number: _____

In Case of Emergency Contact: _____

Telephone Number: (_____)_____Relation to Student:_____

Place of Employment:_____Work Number: (_____)_____

Family Doctor: (Name)_____Telephone Number: (_____)_____

_____
Address City State ZIP

List all allergies the student has (medicines, insect bites, etc.): _____

Currently taking medication? Please list: _____

Please list History of Illness in student's family (i.e. heart conditions, diabetes, etc.)_____

_____

Please list over-the-counter medications that should NOT be administered:_____

_____

Date of student's last tetanus vaccination:_____Is the student allergic to penicillin: Yes_____No___

Is the student capable of participating in physical education activities? Yes____No____

Do you have hospitalization insurance? Yes____No_____If YES, please provide name of company and policy number:

Company:_____**Policy Number:**_____

Do you have a Kentucky Medical Assistance Card? Yes____No_____If YES, please provide the card number below and attach a copy of the current card for the student. **Medical Card Number:** _____

PLEASE PROVIDE A COPY OF THE STUDENT'S IMMUNIZATION RECORD; YOU MAY OBTAIN THIS FROM YOUR COUNTY HEALTH DEPARTMENT OR FROM THE HIGH SCHOOL.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO STUDENT: _____

***NOTE: Please use the back of this form to provide any additional information concerning medical history that you feel the ACTION Program staff should know.*

ACTION Summer Program
University of Kentucky

Authorization to Obtain Medical and Dental Assistance

_____ _____
(Student Full Name) (Student Date of Birth)

I hereby request and authorize UK ACTION staff to obtain medical or dental assistance for my son/daughter.

This authorization also covers medical assistance in a hospital Emergency Room or at any Health Care Facility should such assistance be required.

_____ _____
Parent/Guardian Signature Date

HealthCare

DOS

- University of Kentucky A.B. Chandler Hospital
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Health Clinics

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date:_____ Time:_____ (Patient Label Here)

I understand that as part of my health care, University of Kentucky and its affiliates originates and maintains health records. These health records describe my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and medical treatment information to my bill
- a means by which a third-party payer (i.e. insurance company) can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

The University of Kentucky and its affiliates' ***Notice of Privacy Practices*** gives a more complete description of how my health information may be used or disclosed. The notice also explains my rights regarding my personal health information, including the right to access my own records and the right to request restrictions as to how my health information is used or disclosed.

I understand it is my responsibility to notify University of Kentucky and its affiliates regarding any restrictions to disclosure of my health information regarding this or any subsequent visit.

I have been provided with a *Notice of Privacy Practices* and have been given the opportunity to review this notice.

**Camper is a minor, therefore this form must be signed by the Parent/Guardian/Legal Representative

_____

Signature of Patient or Legal Representative Date

_____

Witness Date

UNIVERSITY OF KENTUCKY

MEDICAL AUTHORIZATION

AUTHORIZATION TO RELEASE INFORMATION		
I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment-related information concerning the patient, to the Plan administrator or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.		
Signature (Parent or Guardian if claimant is a minor)	Date	Phone No.
PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.		
Signature (Parent or Guardian if claimant is a minor)		Date

UNIVERSITY OF KENTUCKY **Camps, Conferences & Field Trips**

MEDICAL INSURANCE INFORMATION FORM

Participant Name:_____
Last First Middle I.

Address:_____
Street Apt. #

_____
City State Zip Code

Age:_____ Date of Birth:_____

Parent/Guardian Name(s):_____

Business phone: mother:_____ step mother:_____
father:_____ step father:_____

Home phone: mother:_____ step mother:_____
father:_____ step father:_____

Neighbor or Relative (Other than parent/guardian): Phone:_____

PRIMARY INSURANCE INFORMATION

PARENT'S INSURANCE COVERING PARTICIPANT

Insured:_____ Date of Birth:_____

Policy No.:_____ Member ID #.:_____

Insurance Co.:_____ Phone #:_____

Insurance Co. Address.:_____

SECOND PARENT'S INSURANCE (if participant is also covered under this policy)

Insured:_____ Date of Birth:_____

Policy No.:_____ Member ID #.:_____

Insurance Co.:_____ Phone #:_____

Insurance Co. Address.:_____

✓ **Check and sign if participant has no health coverage.**

There is no health insurance coverage for this participant at this time.

Signature Parent/Guardian.:_____ Date:_____

You MUST submit a copy of the front and back of all insurance and Rx identification cards covering participants.

CLEAR PAGE

ACTION Summer Program

Student Contract

Student Name: _____

(Please Print)

As a member of the UK Markey Cancer Center ACTION Program, I accept the following responsibilities and agree to:

1. Attend all ACTION scheduled activities
2. Follow all ACTION and University of Kentucky rules
3. Conduct myself as a lady or gentleman at all times
4. Uphold the policies of the ACTION Program
5. Strive to develop leadership qualities
6. Adhere to the ACTION Program disciplinary policy
7. Be respectful to ACTION staff, students and others.

As a member of the UK Markey Cancer Center ACTION Program, I accept responsibility for the fulfillment of the above obligations. I understand that failure to attend and/or participate in ACTION Program activities, maintain the academic standards, or fulfill the requirements of this contract could result in my dismissal from the program.

I understand that the summer program is the most influential component of ACTION and I will make a firm commitment to attend the summer program. I promise to be in attendance, abide by the rules and regulations, and participate fully in all activities. I further understand that failure to comply with this regulation will result in my dismissal from the ACTION Program.

I further understand that the following behaviors will result in automatic dismissal from the ACTION Program and I WILL NOT engage in any of the following:

1. Possession of alcohol or illegal drugs
2. Sexual misconduct
3. Physical or verbal abuse of staff or another student
4. Possession of weapons or fireworks
5. Stealing or shoplifting
6. Intentional damage of property: public, personal or private
7. Out of the residence hall/hotel room past curfew

Student Signature: _____ Date: _____

As the parent or legal guardian of the above-named student, I agree to support the rules and decisions of the ACTION Program. I understand that if my son or daughter breaks any of the rules listed above I will be responsible for the expense of transportation home should my child be dismissed from the summer program.

Parent Signature: _____ Date: _____