# Seeing Yourself in Science®

www.clec-education.com; (816)-875-0111; email: clect@ymail.com

## Participant Registration Form

***A separate form must be completed for each child.*** **Please Print.**

**SECTION I: Child information**

Please enter information for your child indicated below.

**First Name:** _____

**Last Name:** _____

**Address:** _____

**(include city, state, zip)**

**Does this Child live with this Parent/Grandparent/Guardian? Please √ one.**

- ○ Yes
- ○ No

**Access for Students with Disabilities**: Any family with a child requiring an accommodation due to a disability under the Americans with Disabilities Act, must contact us at least two weeks in advance. (816)-875-0111.

**Ethnicity:** (Please select √ one or fill in other) **Age** _____

- ○ African American
- ○ Alaskan Native/ Native American
- ○ Asian/ Native Hawaiian/ Pacific Islander
- ○ Caucasian/ Non-Latino(a)
- ○ Hispanic/ Latino(a)
- ○ Other _____

**Name of Current School and Grade (as of program date)**:

_____

To better accommodate my child's learning style and developmental needs, I also give my permission for the appropriate program staff to obtain and discuss information about my child's grades, attendance, and conduct/behavior from the school. I also expect all such information to be treated confidentially. I consent to this based upon my signature at the end of this registration form.

**SECTION II: Parent/Guardian Information**

**Full name:** _____

**Address:** _____

**(include city, state, zip)**

**Phone 1:** _____ **Phone 2:** _____ **Email address:** _____

**Program Photography & Video:** I understand photographs and video footage may be taken of my child for future SYIS marketing purposes, and I give consent for my child's image to be used. **Please √ one.**

- ○ Yes
- ○ No

**How did you hear about the Seeing Yourself in Science (SYIS) Program? Please √ all that apply.**

- ○ Email
- ○ Flyer or Brochure
- ○ School
- ○ Religious or Community Organization
- ○ Online
- ○ Word of Mouth

**SECTION III: Emergency Contact**

To be used when the parent/guardian cannot be reached. (Must be 18 years of age or older.)

**Emergency Contact Full Name: _____**

**Relationship to child**:

- ☐ Step Parent
- ☐ Grandparent
- ☐ Uncle/Aunt
- ☐ Sibling
- ☐ Family Friend
- ☐ Other _____

**SECTION IV: Medical Information**

Indicate any special needs, important medical history/behavior and/or accommodations that can be made to make your child's experience more successful.

- ☐ Not Applicable
- ☐ Vision Problems
- ☐ Depression/Anxiety
- ☐ Autism
- ☐ Asthma
- ☐ Bone, Joint or Muscle Problems
- ☐ ADD or ADHD
- ☐ Behavior or Conduct Problems
- ☐ Diabetes
- ☐ Any Developmental Delay or Physical Impairment
- ☐ Hearing Problems
- ☐ Allergies

Additional Comments: _____

**IMPORTANT** If your child will need to take over-the-counter or prescription medications during the program time, the **medications/prescriptions and release and waiver of liability FORMS** must be completed.

If the child uses an inhaler and is authorized to self-administer, the medications/prescriptions **FORM** must be completed. No member of Seeing Yourself in Science program will administer medications, but the child may take them/it, so long as physicians or parents/guardians have authorized self-administration. If the child is not allowed to self-administer their medication, parents/guardians or a pre-authorized individual are welcome to come to the site to dispense the medication when necessary.

If the child needs to bring an epinephrine syringe to be administered in the event of a severe allergic reaction, the **medications/prescriptions and release and wavier of liability FORMS** must be completed.

**Medical/Dental/Hospital Emergency**

In case of an emergency requiring medical and/or dental treatment and/or hospitalization, I give my consent for any treatment deemed necessary by the physician, dentist and/or hospital as indicated below.

Physician: _____ Phone Number: _____

Dentist: _____ Phone Number: _____

Hospital: _____ Phone Number: _____

*In the event that the designated preferred physician, dentist and/or hospital, as applicable, is not available, I hereby give my consent for the administration of any treatment deemed necessary by another licensed physician or dentist at any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists (as applicable), concurring in the necessity for such surgery, are obtained before surgery is performed.*

**SECTION VI: Acceptable Behavior Policy**

All children are entitled to a positive and rewarding experience while attending the program. In order to ensure a safe and fun environment for all, children are expected to behave in an acceptable manner and use appropriate language. ANY behavior deemed to be detrimental to or in violation of Seeing Yourself in Science standards will be dealt with by the staff and/or Program Director/Coordinator. Unacceptable behavioral instances include, but are not limited to: any form of intended harm to another student or staff member, bullying or any form of aggression. Any situation that involves distracting other participants or disrupting program activities will not be tolerated. We understand that Seeing Yourself in Science staff have the right to remove any person from the program that does not abide by these rules.

By signing this program registration form, parents/guardians and the participating student signify their understanding and agree to abide by and adhere to the rules of the Acceptable Behavior Policy.

I/We also understand that Seeing Yourself in Science is not responsible for personal items my child brings such as electronic devices, games, cell phones, money, etc.

**SECTION VII: Acknowledgement and Signature**

I am the parent/legal guardian of (“the participant/child"). On my own behalf and as parent/guardian, I acknowledge and agree that there is the possibility of physical injury or loss associated with my child’s participation in the program. I hereby release, discharge Seeing Yourself in Science, its affiliated organizations, employees and associated personnel including the owners of the program facility against any and all claims, liabilities and/or damages as a result of my child’s participation in the program, including but not limited to, any claim that Seeing Yourself in Science was negligent. I further agree to defend and indemnify Seeing Yourself in Science, its affiliated organizations and subcontractors and associated personnel if any claim is made against them by or on behalf of my child. I understand that my child will not be permitted to participate in the program without my signing this Agreement. Finally, I acknowledge that Seeing Yourself in Science is a Missouri organization and I agree that Missouri law will govern the interpretation and validity of this liability waiver.

**Parent/Guardian Signature: _____ Date: _____**

**Parent/Guardian Name (PRINT): _____**