Texas Undergraduate Medical Academy

Prairie View A&M University

College Readiness and Community Engagement Training Program Application

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Cell Phone: _____

Email _____

Name of High School: _____

GPA: _____

Classification (2018-2019 academic year): _____

Extra Curricular/Community Service Activities

Organization: _____

Position: _____

Description: _____

_____

_____

_____

Organization: _____

Position: _____

Description: _____

_____

Organization: _____

Position: _____

Description: _____

_____

_____

Organization: _____

Position: _____

Description: _____

_____

_____

_____

Reference

Please list the name of one professional reference. Please attach letter of reference to this application.

Full Name: _____
Last *First* *M.I.*

Email Address: _____

Primary Phone: _____ Cell Phone: _____

Relationship: _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

Signature: _____

PRAIRIE VIEW A&M UNIVERSITY

WAIVER, INDEMNIFICATION, AND MEDICAL TREATMENT AUTHORIZATION FORM

1. EXCULPATORY CLAUSE. In consideration for receiving permission to participate in any and all activities of _____ ("activity"), which is sponsored by _____ Prairie View A&M University, a member of The Texas A&M University System, I hereby release, waive, covenant not to sue, and agree to hold harmless for any and all purposes sponsor, The Texas A&M University System, the Board of Regents for The Texas A&M University System, and their members, officers, agents, volunteers, or employees ("RELEASEES" or "INDEMNITEES") from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while participating in this activity, while traveling to and from the activity, or while on the premises owned, leased, or controlled by RELEASEES, ***including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of RELEASEES.*** I understand this waiver does not apply to injuries caused by intentional or grossly negligent conduct.

2. INDEMNITY CLAUSE. I am fully aware that there are inherent risks to myself and others involved with this activity, including but not limited to _____, and I choose to voluntarily participate in this activity with full knowledge that the activity may be hazardous to me and my property, and to the person and property of others. I acknowledge there may be physically strenuous activities. I know of no medical reason why I should not participate. ***I agree to indemnify and hold harmless INDEMNITEES*** from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, which may occur to myself, other participants, and third-persons as a result of my participation and conduct in this activity, ***including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of INDEMNITEES.***

3. NO INSURANCE. I understand that RELEASEES do not maintain any insurance policy covering any circumstance arising from my participation in this activity or any event related to that participation. As such, I am aware that I should review my personal insurance coverage. Sponsor does not carry general liability insurance to cover claims arising from this activity so it seeks a waiver of claims as additional consideration for the right to participate so sponsor, a governmental unit of the State of Texas, can (a) provide the activity at the lowest possible cost to participants; and (b) provide access to a greater number of participants by expending limited resources on program materials rather than on liability insurance.

4. BINDS HEIRS. It is my express intent that this agreement shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representatives, if I am deceased, and shall be governed by the laws of the State of Texas.

5. MEDICAL AUTHORIZATION, INDEMNITY FOR MEDICAL EXPENSES, and WAIVER. I understand RELEASEES cannot be expected to control all of the risks associated with this activity and RELEASEES may need to respond to accidents and potential emergency situations. Therefore, I hereby give my consent for any medical treatment that may be required, as determined by a medical professional at the medical facility, during my participation in this activity with the understanding that the cost of any such treatment will be my responsibility. I agree to indemnify and hold harmless INDEMNITEES for any costs incurred to treat me, even if an INDEMNITEE has signed hospital documentation promising to pay for the treatment due to my inability to sign the documentation. I further agree to release, waive, covenant not to sue, and agree to hold harmless for any and all purposes, RELEASEES from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while receiving medical care or in deciding to seek medical care, including while traveling to and from a medical care facility, ***including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of RELEASEES.*** I understand this waiver does not apply to injuries caused by intentional or grossly negligent conduct.

6. VOLUNTARY SIGNATURE. In signing this agreement I acknowledge and represent that I have read it, understand it, and sign it voluntarily as my own free act and deed; sponsor has not made and I have not relied on any oral representations, statements, or inducements apart from the terms contained in this agreement. I execute this document for full, adequate and complete consideration fully intending to be bound by the same, now and in the future. **For students engaging in extracurricular activities:** I understand I can choose not to sign this document and free myself from its terms and the associated risks of the activity by simply not participating in the activity and choosing some other activity available to me that has a lower level of risk to me. I further understand this is a voluntary, extracurricular activity; therefore it is not required for me to obtain college credits and not participating in this activity will in no way hinder my ability to obtain a degree from the university. **For students going on fieldtrips or other class-related activities:** I understand participation in this class/fieldtrip/activity is not mandatory and I will not be penalized for failing to participate in this activity because an alternative activity exists for which I can receive like credit. While I understand alternative activities are available to me that do not have the risks associated with this activity I still desire to voluntarily engage in this activity.

SIGNING THIS DOCUMENT INVOLVES THE WAIVER OF VALUABLE LEGAL RIGHTS. CONSULT YOUR ATTORNEY BEFORE SIGNING THIS DOCUMENT.

SIGNED this _____ day of _____, 20_____.

Participant Signature: _____

Printed Name: _____

Participant's Date of Birth: _____

Parent or Legal Guardian Signature: _____
(If Participant is under 18 years old)

Parent or Legal Guardian Printed Name: _____
(If Participant is under 18 years old)

INSTRUCTIONS: (1) The document should be printed in a font size no smaller than 10-point type. This is 10-point type. This is 12-point type. (2) The formatting/font style (***bolded, underlined, and italicized***) in paragraph nos. 1, 2, 5 & 6 should not be altered.

TAMUS-OGC-Approved 5/7/2015

PRAIRIE VIEW A&M UNIVERSITY

Pick Up Authorization and Health Information Form

I. EMERGENCY CONTACT INFORMATION

1. Participant Name:

First _____ Last _____

2. Parent / Legal Guardian Information:

First _____ Last _____

Address _____ E-mail Address _____

Primary Phone _____ Secondary Phone _____

II. PERSONS AUTHORIZED TO PICK-UP CHILD

In addition to the parent/guardian(s) listed above, please list the names of any possible persons authorized to pick up the above referenced child. Use the other side of this form to add additional names. Please Note: Photo ID's must be presented at the time of pick up.

First Name	Last Name	Relationship to Child	Phone Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

III. AUTHORIZATION FOR SELF-CHECKOUT

Program participants will only be released at the scheduled program ending times, or times designated to the program by the parent/legal guardian. Please select from the check-out options listed below.

☐ I do not grant my child permission to self-checkout from this program. Only the individuals listed above are authorized to pick-up and sign-out my child.

☐ I will not be escorting my child to and/or from the program and grant my child permission to travel to and/or from the program and check-out independently at the conclusion of the program.

PHOTO & VIDEO RELEASE

I, _____, as the parent and/or guardian of _____, authorize Prairie View A&M University to photograph or video my son/daughter and to use the photographs or videos for educational or promotional purposes in any media format chosen. I understand that photographs or videos may not be used for profit without my express permission. I acknowledge that I will not be paid or rewarded for providing this authorization. **INITIALS**_____

HEALTH INFORMATION

Is there anything in youth's health history that the program staff should know?_____

_____

Are there any activities from which the youth should be restricted?_____

Please list any special services your child may require_____

Does the youth have any special dietary restrictions? ☐NO ☐YES If YES, explain_____

_____

Please list any allergies_____

Does the youth wear any medical appliances (glasses, contact lenses, orthodonture, etc.)? ☐NO ☐YES If YES, explain_____

_____ _____

Parent/Legal Guardian Name (Please Print) Parent/Legal Guardian Signature & Date

PRAIRIE VIEW A&M UNIVERSITY

AUTHORIZATION FOR DISPENSING MEDICATION

IF NO MEDICATION IS REQUIRED PLEASE SIGN BELOW(*)

PARENT'S AUTHORIZATION

Name of Child to Receive Medicine		Name of Medication
Prescribing Physician	Prescription No.	Expiration Date
Dosage	When to Give	Continue Medication Until (date)

NOTE: Medication must be in its original container and labeled with your child's name and the date medication is left at the facility. Medication can only be administered in amounts according to the label directions.

Signature-Parent or Guardian (*) Date

CAREGIVER'S RECORD OF ADMINISTERING MEDICATION

CHILD'S NAME	NAME OF MEDICATION	DATE GIVEN	TIME GIVEN	AMOUNT GIVEN	FULL NAME OF CAREGIVER OR EMPLOYEE

Disposition of Left-over Medication

☐ Returned to Child's Parent/Guardian ☐ Thrown Away Date: