MUW SCIENCE ENRICHMENT PROGRAM
FIELD TRIP WORKSHOP REGISTRATION PACKET

To complete this packet, you must turn in completed forms for:

1.) *One teacher/adult form for yourself and any adult chaperones (2 pages)*
2.) *One youth form per student participant (2 pages)*

Please indicate the date(s) and title(s) of the workshop(s) for which you are applying in order of preference:

1. ____

2. ____

3. ____

Applicant Name: ____
Last First Middle Initial

Mailing Address: ____
Number and Street, Box or Route City, State, Zip Code

Telephone (best to reach you): ______________________________

E-mail Address (best one): ____

Gender: □ Male □ Female

Race/Ethnicity (optional): □ African American/Black □ Asian/Pacific Islander
□ Caucasian/White □ Hispanic □ Native American □ Other

School Where You Teach: ____

School Description: ____
(student body, funding, demographics, etc.)

City and State: ______________________________

District: ______________________ Years of Teaching Experience: __________

Grade(s) Taught: ______________ Subject(s) Taught: ______________________

Mississippi University for Women does not discriminate on the basis of race, color, religion, gender, age, sexual orientation, national origin, disability, or veteran status in admission, in treatment, in employment, or in access to its programs and activities.

In case of emergency, please contact:

Name ____Relation______________________

Phone 1.______________________________ 2.________________________________

Address ____

City __________________________ State _________ Zip ___________________

MEDICAL HISTORY

Please list any health conditions (illness, allergies, limitations, or medications) or special circumstances of which we should be aware that might help us in better preparing for your participation. ____

____

____

Insurance Carrier____

Policy # ____________________________________ Group # __________________________

Address of carrier ____

____

I have a fear of water: Yes □ No □

My photo may be used by the SEP for future promotional materials: Yes □ No □

It is expressly understood and agreed that the Mississippi University for Women shall not be responsible or legally liable for any losses of personal property or for any bodily injuries, or the results thereof, incurred and suffered by the participant in connection with any activities of programs.

Print Name ____

Signature ____ Date____________________

Registration forms will be accepted until sessions are full. Slots will fill on a first-come-first-served basis. To check capacity status, log on to our website at:
http://www.muw.edu/sci_math/sep

Please e-mail digitally completed forms to: klangley@as.muw.edu
or mail completed forms to:
Kenny Langley
1100 College St., MUW-100
Columbus, MS 39701-5800

MUW Science Enrichment Program (SEP)
YOUTH MEDICAL & WAIVER FORM

Workshop date and title of workshop for which you are applying: ____________________________

____ Supervising Teacher: _________________________

Student Participant Name ____

D.O.B. _________________ Age __________ Gender: M □ F □

Parent/Guardian Name ____

Relation to Guardian ____

Address ____ City ___________________________

State ___________ Zip _________________

Phone (Day) _____________________________ Phone (Night) _______________________________

E-mail ____

Name of School ____ Current Grade__________

If Parent/Guardian is unavailable in an emergency, please contact:

Name ____ Relation ____________________________________

Phone _______________________ Address ____

City _______________________________ State ___________ Zip _______________________

HEALTH & ALLERGY HISTORY (please check any and all that apply)
Ear Problems □ Hay Fever □ Poison Ivy □

Bleeding Disorder □ Heart Disease/Defect □ Diabetes □

Insect Sting □ Asthma □ Seizures/Convulsions □ Inhaler □

Penicillin □ Carry Sting Kit □

Other conditions, illness, allergies, limitations, or medications:_______________________________

____

Restricted Activities:____

Reason:____

Last Tetanus Shot (date) ____________________________

Name of Family Physician _________________________________ Phone # __________________

Do you have Family Medical/Hospital Insurance? Yes □ No □

If Yes, name of carrier____________________________________

Policy # ____ Group # _____________________________

Address of carrier ____

Does your child have a fear of water? Yes □ No □

My child's photo may be used by the SEP for future promotional materials: Yes □ No □

The health history in this form is correct and complete and the person herein described has permission to engage in all prescribed activities except those listed above. I hereby give permission to the physician selected by the Program Coordinator to order x-rays, routine tests, and treatment for the health of my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Project Coordinator to hospitalize, secure proper treatment for, and order injection, and or anesthesia, and or surgery for my child as named above and I accept financial responsibility for all treatment.

It is expressly understood and agreed that the Mississippi University for Women shall not be responsible or legally liable for any losses of personal property or for any bodily injuries, or the results thereof, incurred and suffered by the participant in connection with any activities of programs.

Parent/Guardian Print Name ____

Signature ____

Date _____________________________