THE BE PROJECT

Black College Experience

WWW.THEBEPROJECTS.ORG | INFO@THEBEPROJECTS.COM

PARTICIPANT INFORMATION AND AUTHORIZATION FORM

This form must be completely filled out to participate with The BE PROJECT tours/activities.

Print clearly and fill out all sections completely (mark N/A if it does not apply) and sign and initial where indicated. Additional information may be required. If there are any changes in the information on this form, please contact THE BE PROJECT staff immediately to update.

I. PARTICIPANT INFORMATION

First Name (LEGAL NAME ONLY)	Middle	Last	Suffix (Jr., II, III)	Nick Name

Birth Date	Age	Gender	Ethnicity	Grade	School
		☐ Male ☐ Female			

Participants Cell Phone Number	Texting Okay	Participants E-Mail Address
	☐ Yes ☐ No	

How did you hear about us?

II. PARENT / GUARDIAN CONTACT INFORMATION

Primary / Enrolling Contact – Parent / Guardian Name (first & last)	Relationship

Primary Phone ☐ Cell ☐ Home ☐ Work	Secondary Phone ☐ Cell ☐ Home ☐ Work	Texting Okay
		☐ Yes ☐ No

Address	Apt #	City	State	Zip
			WA	

Parent Primary E-mail Address	Secondary / Alternate E-Mail Address

III. EMERGENCY CONTACT INFORMATION

The Parent/Guardian, above, will be contacted first in case of emergency, after 911. Please list non-registering parent/guardian and others you would like us to contact in the event you cannot be reached.

1) Name (first & last)	Relationship

Primary Phone ☐ Cell ☐ Home ☐ Work	Secondary Phone ☐ Cell ☐ Home ☐ Work	Texting Okay
		☐ Yes ☐ No

2) Name (first & last)	Relationship

Primary Phone ☐ Cell ☐ Home ☐ Work	Secondary Phone ☐ Cell ☐ Home ☐ Work	Texting Okay
		☐ Yes ☐ No

IV. PARTICIPANT HEALTH HISTORY INFORMATION

1. Is your child on any medication?	☐ Yes ☐ No
2. Does your child currently have asthma, diabetes or a medical condition that requires him / her to receive medication or additional health procedures?	☐ Yes ☐ No
3. Does your child have any allergies, dietary restrictions, or physical activity limitations?	☐ Yes ☐ No
4. Does your child have any other illness, injury, social/emotional needs or medical conditions which staff and volunteers should be made aware of?	☐ Yes ☐ No
5. Does your child require any special accommodations or needs?	☐ Yes ☐ No
6. Does your child have any special fears or challenges?	☐ Yes ☐ No
7. Is there anything else about your child's health or behavioral issues we should know about?	☐ Yes ☐ No

If you answered yes to any of the questions above, please explain.

FOR OFFICE USE ONLY T-shirt size: _____ Name:_____

PARTICIPANT ☐ New ☐ Returning

PAID Deposit received_____ Receipt # _____ Amount $ _____

Childs Name (First & Last)	Birth Date	Age	Gender ☐ Male ☐ Female	Ethnicity

V. INSURANCE INFORMATION

1. ☐ My Child has medical insurance coverage with:

Insurance Company Name	Policy Number	Phone Number	Policyholder's name (please print)

Physician Name:

2. ☐ My Child has dental insurance coverage with:

Insurance Company Name	Policy Number	Phone Number	Policyholder's name (please print)

Dentist Name:

3. ☐ My Child **DOES NOT** have medical/dental insurance coverage at this time (**this will not jeopardize participation**)

VII. PARENT / GUARDIAN ACKNOWLEDGEMENT

Please read the following carefully and acknowledge your agreement by signing below.

Liability Release

I hereby consent for my child to participate in selected events by THE BE PROJECT.

I hereby consent for my child to travel to and from THE BE PROJECT via THE BE PROJECT approved transportation.

I have told my child to obey all directions of the staff and to comply with all safety instructions and refrain from unsafe practices.

I have received a copy of THE BE PROJECT rules, expected behavior and code of conduct.

I understand that should my child act in a manner that is considered unacceptable and or unsafe for themselves, other participants and or staff, they may be excluded from the program.

Authorization for Emergency Medical Treatment

I hereby authorize and consent to the administration of any and all medical, dental and surgical examinations or operations and treatment or all other related care, including emergency transportation or ambulance transportation, the administration of drugs, tests, anesthesia and / or blood transfusions to the above minor person that may be ordered by a physician and or dentist in attendance at the medical center deemed necessary in the event of an injury, illness or emergency treatment.

I hereby consent to the release of medical report(s) to any doctor or agency and consent to the admission of the above name minor person to the hospital.

Indemnity Agreement

I hereby waive on behalf of myself and the above child any liability of the THE BE PROJECT or for any of it officers, agents, staff, or volunteers, for injuries, financial obligation, or liability in case of my child's accident, injury or illness sustained in the program.

I hereby accept full financial responsibility in the event of an injury, illness or emergency treatment for my child.

I hereby accept legal responsibility in the event of an injury, illness or emergency treatment for my child.

Financial Agreement

I understand and acknowledge that there are additional cost associated with participating in THE BE PROJECT HBCU Experience. **Costs will include meals, extracurricular activities, and incidentals**. I understand that if all fees are not paid in full by the due date my child's participation WILL be terminated and any deposits shall be forfeited. ALL DEPOSITS ARE NONREFUNDABLE.

Photo / Video / Media Release

A representative may gather photographs and /or video footage highlighting the event. We value your child's participation, and ask for your permission to include him or her. Please indicate by initialing below of your consent.

_____ I give my permission to have my child photographed / videotaped by the organization. Photos and videos may be used by the organization for presentations and / or website.

_____ Please DO NOT include my child in these activities. I DO NOT want my child photographed or videotaped.

By signing below, I acknowledge and I am in agreement with the Liability Release, Authorization for Emergency Medical Treatment, Indemnity Agreement, Financial Agreement and Photo/Video/Media Release. A photo copy of this form can be used as an original.

Parent/Legal Guardian signature **Date**