CHAPERONE FORM

Jackson State University National Alumni Association, Inc.
METRO ATLANTA CHAPTER, INC. P.O. Box 57122, Atlanta, GA 30343
RECRUITMENT@jsumac.org 404-266-7933

REGISTRATION AND MEDICAL FORM

JACKSON STATE UNIVERSITY HIGH SCHOOL & TRANSFER DAY

SATURDAY, NOVEMBER 2, 2019

CHAPERONE INFORMATION

NAME: _____

ADDRESS: _____ _____

MALE _____ FEMALE _____ RACE _____

EMAIL _____ CELL PHONE _____

ARE YOU A JSU ALUMNI OR JSU ASSOCIATE MEMBER? _____ YES _____NO

PLEASE CHECK YOUR MEAL PREFERENCE: _____BEEF HAMBURGER

_____ VEGGIE BURGER

Permission to Transport/ Waiver of Liability

I _____ give Jackson State University National
(print name legibly)
Alumni Association, Inc. (JSUNAA) Metro Atlanta Chapter, Inc. permission to transport me to all functions and activities. I agree to abide by the rules of JSUNAA Metro Atlanta Chapter, Inc. I understand that all of the JSUNAA Metro Atlanta Chapter, Inc. or any agents therein, shall not be liable for any injuries to myself and/or property, or damages resulting from acts of active or passive negligence on the part of JSUNAA Metro Atlanta Chapter, Inc., its officers, or agents. I do hereby release and discharge JSUNAA Metro Atlanta Chapter, Inc. of its successors and assigns, as well as its officers and agents, for such claims, demands injuries, damages, actions or cause of action.

_____

Individual Signature Date

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MEDICAL INFORMATION/MEDICAL RELEASE FORM

Individual Name (please print ***in black or blue ink*** in boxes below)

First _____

Last _____

MEDICAL INFORMATION

ALLERGIES (Please include all food, medication, and environmental allergies)
_____

MEDICATIONS/CONDITIONS: _____

_____

ANY EXCEPTIONS: _____

Emergency Contacts

In the event of an emergency, please contact the below listed person:

Name: _____
Day: _____ Evening: _____
Relationship: _____

MEDICAL RELEASE
I give my permission to have her/him treated by a licensed physician if necessary. I also agree to be financially responsible for all expenses associated with providing medical care for my child. Medical treatment includes transportation for my child by emergency vehicle to an appropriate health care facility and pre-hospital medical care, all hospital and physician services, whether medical, surgical and/or dental, necessary for the benefit/safety/well-being of my child.

Individual Signature: _____Date: _____

*Please email scan the form back to RECRUITMENT@JSUMAC.ORG or fax to 678-609-4747

PLEASE ATTACH OR SEND A PHOTO via email, fax or text (to KEITH ADAMS KTADAMO6@YAHOO.COM OR DEBCTAY@YAHOO.COM