



# Emergency Information, Releases & Health History

**INSTRUCTIONS:** Please provide detailed health information for determining appropriate supervision, support, and accommodations for the Virginia Tech activity/event listed. **A parent or guardian must sign.** If the participant is a person with a disability and desires any assistive devices, services or other accommodations to participate in this activity, please contact the program's facilitating department office during business hours at least 7 days prior to the event to discuss accommodations. **PLEASE PRINT ALL INFORMATION.** (NOTE: Both sides of this form must be completed.) **Please provide a copy of the student's picture ID and the front and back of the insurance card(s).**

Program or event in which you wish to participate: Virginia Governor's School for Agriculture  
Date(s) of event: June 25, 2023 - July 22, 2023 Location: Virginia Tech, Blacksburg, Virginia

## PARTICIPANT IDENTIFICATION

Name: \_\_\_\_\_ Gender: Male Female  
Last First (Underline name by which you like to be called) Middle  
Mailing address: \_\_\_\_\_ Participant cell phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Home phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Home email: \_\_\_\_\_  
Ethnicity (choose one): Hispanic/Latino  Not Hispanic/Latino   
Race (choose all that apply): American Indian/Alaskan Native  Asian  Black/African American   
Native Hawaiian/Other Pacific Islander  White

## PARENT / GUARDIAN IDENTIFICATION (Place a check beside who to reach in the event of an emergency.)

First parent/guardian name: \_\_\_\_\_ First parent/guardian email: \_\_\_\_\_  
First parent/guardian phone daytime: \_\_\_\_\_ Evening: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Second parent/guardian name: \_\_\_\_\_ Second parent/guardian email: \_\_\_\_\_  
Second parent/guardian phone daytime: \_\_\_\_\_ Evening: \_\_\_\_\_ Cell: \_\_\_\_\_  
Who has primary custody of the participant? \_\_\_\_\_  
Address, if different than child: \_\_\_\_\_

## PHYSICIAN / INSURANCE INFORMATION

Family physician name: \_\_\_\_\_  
Phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
Dentist/orthodontist name: \_\_\_\_\_  
Phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
**Do you carry family medical / hospital insurance?:** Yes  No   
(Check  one)  
Carrier: \_\_\_\_\_  
Policy ID #: \_\_\_\_\_

## VIRGINIA TECH PARTICIPANT MEDIA RELEASE

For valuable consideration received, the undersigned hereby irrevocably consents to and authorizes the use by Virginia Polytechnic Institute and State University ("Virginia Tech") of the undersigned's name, image, voice, likeness, and/or student-created work as follows: Virginia Tech shall have the right to publish, re-publish, adapt, exhibit, perform, reproduce, edit, modify, make derivative works, distribute, display or otherwise use or re-use the undersigned's name, image, voice, likeness, and/or student-created work in connection with any product or service in all markets, media or technology now known or hereafter developed in perpetuity throughout the universe including advertising, promoting and merchandising the product or service. Virginia Tech may exercise any of these rights itself or through any successors, transferees, licensees, distributors or other parties, commercial or nonprofit.

I understand that I will need to notify Virginia Tech if any changes to my situation occur that will impact this media release permission.

Yes  No

## EMERGENCY CONTACT INFORMATION (Parts 1 and 2 should be completed)

1. Where can you be reached in the event of an emergency?  
Phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
Cell phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
2. If you **Cannot** be reached, who should be notified?  
Name: \_\_\_\_\_  
Home phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
Work phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
Cell phone: ( \_\_\_\_\_ ) \_\_\_\_\_

(continued on back)

**PARTICIPANT HEALTH AND MEDICAL HISTORY**  
(Questions 1-5 must be completed.)

**1. SPECIAL DIETARY NEEDS**

*INSTRUCTIONS: The purpose of this section is to communicate special dietary needs, food allergies, etc. for any child, teen, or adult who will be attending a Virginia Tech event. In the space below, please list all **food allergies and/or other dietary restrictions** for the person listed above and any necessary precautions that should be taken:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2.** Has the participant ever experienced (or had special needs in) any of the following?  
[Check (✓) all that apply]

- Asthma                       Bleeding disorders                       Attention disorders (ADHD)  
 Eating disorders                       Seizures/Convulsions                       Wears contacts  
 Diabetes                       Bed Wetting                       Behavior  
 Fainting spells                       Non-food allergies                       Other: \_\_\_\_\_

*Please describe any condition or need that you checked:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3.** Is the participant experiencing any current health problems, under medical care, receiving mental or behavioral services, or **currently taking medication**?

YES      NO      If YES, please explain: \_\_\_\_\_

\_\_\_\_\_

**4.** Has the participant undergone surgery, or experienced any injury, illness, allergy, or change in health status any time during the last year? Is there any reason that participation in a program or activity should be restricted?

YES      NO      If YES, please explain: \_\_\_\_\_

\_\_\_\_\_

**5.** What else should we know about your child?

Virginia Tech programs include very rewarding, but sometimes challenging situations. Please inform us of any concerns that may arise related to your child's physical, mental, emotional, and/or social health in order that we may better provide appropriate supervision and support.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**APPROVAL / EMERGENCY AUTHORIZATION**

(Please read parts 1 and 2. If the participant is under 18, parents/guardians must sign in the space provided. If you are over the age of 18, please sign for yourself. If you cannot sign this due to religious reasons, you must contact the department office to obtain a legal waiver that must be signed. **If this section is not signed, participation in the event/activity will not be allowed.** You must contact the main Governor's School office if there is a change in health status after submitting this form.

1. I give my permission for the participant named on this form to attend the designated VA Tech program. He/She has permission to participate in all activities which may include physical activity/exercise and related actions under the supervision of instructors; subject to limitations noted herein.

2. I hereby give permission to the medical staff person selected by the event/activity director to order X-rays, routine tests and treatment for my child (or for myself if I am a participant over 18 years old) as medically necessary. I understand that all attempts will be made to notify parents/guardians of any serious injury or illness to their child. If I cannot be reached in an emergency, I hereby give permission to the medical staff person to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/or the participant named on this form. This form may be photocopied for use outside of the event/activity location.

ADULT PRINTED NAME: \_\_\_\_\_

SIGNED: X \_\_\_\_\_  
(Parent / Legal Guardian or participant over 18 years old)

Date: \_\_\_\_\_

*I understand and agree to abide with any restrictions placed on my activities according to this form.*

YOUTH PRINTED NAME: \_\_\_\_\_

SIGNED: X \_\_\_\_\_  
(Participant under 18 years old)

Date: \_\_\_\_\_

**IMMUNIZATION HISTORY (This must be completed)**

Are your child's immunizations up to date?    YES    NO      Date of most recent tetanus shot: (month/year) \_\_\_\_\_/\_\_\_\_\_

**RELEASE AUTHORIZATION**

I give permission to the following individual(s) to pick up my child at the conclusion of this event (**this person must be 21 years or older and show government issued ID**):

Name(s): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**Sign below at time of pick up** (Receiving person must be pre-listed above):

Name (print): \_\_\_\_\_      Signature: \_\_\_\_\_      Date: \_\_\_\_\_