WV GSE - STUDENT INFORMATION FORM

Print clearly in **black** ink. (Use the white boxes, not the shaded ones)

Full Name

First	Middle
Last	Preferred Name
SSN	Email Address

Date of Birth (mm-dd-yyyy) Age:	Place of Birth

Contact Information

Street Address		Home Phone
City	State and ZIP	Parent's Email Address
High School and County		Preferred Name (to be used on nametag)

Gender (circle one)		Adult T-Shirt Size (circle one)		
Male	**Female**	Small XL	Medium XXL	Large XXXL

Publicity Release

The undersigned hereby grant permission to the West Virginia Governor's School of Entrepreneurship, the West Virginia Department of Education and the Arts, West Virginia University, its representatives and successors to use identified photographs, video and audio recordings, and press releases of the student for the purpose of publicity and other promotions, including Internet publications. The student's name and address may be released to institutions providing educational excellence, and photos and contact information may be printed in a student directory.

Signature of Student	**Date**	**Signature of Parent/Guardian**	**Date**

Release from Liability

The undersigned hereby release the West Virginia Governor's School of Entrepreneurship and its staff, the West Virginia Department of Education and the Arts, and West Virginia University from any and all claims arising from the undersigned student's participation in the WV GSE.

Signature of Student	**Date**	**Signature of Parent/Guardian**	**Date**

Rules Agreement and Field Trip Permission

Having reviewed and discussed (student/parent/guardian) the schedule and rules for the West Virginia Governor's School of Entrepreneurship at West Virginia University, the undersigned student agrees to abide by all rules of the school and commit to attend the GSE from June 25-July 15, 2018. The undersigned parent/guardian gives permission for the student to participate in any field trips planned and organized by the GSE.

Signature of Student	**Date**	**Signature of Parent/Guardian**	**Date**

Consent to Participate

The undersigned student hereby acknowledges that I have read the *Handbook for Students and Parents* and that I agree to participate fully in the activities of the Governor's School of Entrepreneurship. I agree to follow the rules set by the dean, and I fully understand that my cell phone/communicative device will be left in the dorm while I am in class or a planned program or activity unless my teacher requests that it be used in class.

I agree to wear my name tag at all times when I am out of the dormitory.

I, the undersigned parent/guardian of the student named in this document, consent to my child's participation in the GSE. Having read the *Handbook for Students and Parents*, I have discussed behavior expectations with him/her. I assume personal responsibility for any costs of medical attention or injuries my child may sustain as well as for any damage to property resulting from my son's/daughter's behavior.

Signature of Student	**Date**	**Signature of Parent/Guardian**	**Date**

Name: _____

Last, First Middle

WV GSE - EMERGENCY CONTACT AND MEDICAL INFORMATION

The information on this form is gathered to assist us in identifying appropriate care. Any changes of the information on this form after it is sent in should be provided to WV GSE personnel upon your arrival. Provide complete information so that the WV GSE can be aware of your needs. **Please notify the WV GSE if the herein named student is exposed to any communicable disease during the four weeks previous to arrival.**

Emergency Contact #1

Full Name	Relation to Student
Day Telephone	Evening Telephone

Emergency Contact #2

Full Name	Relation to Student
Day Telephone	Evening Telephone

Family Physician

Full Name	Office Address
Day Telephone	Evening Telephone, if available

Permission to Provide Necessary Treatment or Emergency Care

As the legally recognized parent or guardian of the individual named above, by signature below, I hereby give authority and permission to the GSE staff, the staff of West Virginia University, and licensed medical professionals to obtain and provide necessary medical treatment, both physical and mental, including, but not limited to, diagnostic X-rays, routine tests, and treatment, including hospitalization; to release any records necessary for medical or insurance purposes; to provide or arrange necessary related transportation for my child; to administer, as needed, the over-the-counter medications listed below (strike through any exceptions); and to copy this completed form (to accompany the participant on trips outside of our facility). I understand that every practical effort will be made to contact me or other parents or guardians of the participant if a medical emergency occurs. **I have also enclosed a copy of both sides of the medical insurance card that covers the individual named above. (Do NOT send the actual insurance card)**

Over-the-Counter Medications and indications:

- Sunscreen, topically for sun exposure
- Bug Repellant, topically
- Maalox/Tums, for upset stomach
- Milk of Magnesia, for constipation
- Kaopectate, for diarrhea
- Calamine/Anti-itch lotion, topically, for itch/contact dermatitis
- Throat Bacitracin/Triple Antibiotic Ointment, topically, for wound care infection prevention
- Robitussin (Guifenesin), per weight/age dosing for cough
- Benadryl (Diphenhydramine) oral, per directions for weight/age for rash/itch, rhinitis, sneezing, itchy eyes without acute asthma episode
- Tylenol, per weight/age dosing, for pain, fever, headache
- Motrin, per weight/age dosing, for pain
- Throat Lozenge, for sore throat
- Dramamine (Dimenhydrinate)/meclizine, for motion sickness
- Epinephrine and Benadryl, for severe anaphylactic reaction

Signature of Student	Date	Signature of Parent/Guardian	Date

General Questions

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	○	○	15. Ever been diagnosed with a heart murmur?	○	○
2. Have a chronic or recurring illness/condition?	○	○	16. Ever had back problems?	○	○
3. Ever been hospitalized?	○	○	17. Ever had problems with joints? (e.g. knees, ankles)?	○	○
4. Ever had surgery?	○	○	18. Have any skin problems?	○	○
5. Have frequent headaches?	○	○	19. Have diabetes?	○	○
6. Ever had a head injury?	○	○	20. Have asthma?	○	○
7. Ever been knocked unconscious?	○	○	21. Had mononucleosis in the past 12 months?	○	○
8. Wear eyeglasses, contacts, or protective eye wear?	○	○	22. Had problems with diarrhea/constipation?	○	○
9. Ever had frequent ear infections?	○	○	23. Have problems with sleepwalking?	○	○
10. Ever passed out during or after exercise?	○	○	24. If female, have an abnormal menstrual history?	○	○
11. Ever been dizzy during or after exercise?	○	○	25. Have a history of bed-wetting?	○	○
12. Ever had seizures?	○	○	26. Ever had an eating disorder?	○	○
13. Ever had chest pain during or after exercise?	○	○	27. Ever had emotional difficulties requiring professional help?	○	○
14. Ever had high blood pressure?	○	○			

Please explain any "yes" answers, noting the number of the questions (attach additional pages as necessary)._____

Student Name _____ **Med Information Page Two**

If you do not have immunization dates, but your child meets the immunization requirements for West Virginia Public Schools,
Check here: _____

Immunizations (Please fill out as completely as possible.)

Which of the following has the participant had?	**Please give all dates of immunization for:**							
	Vaccine:	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**
	Date:							
	DTP	_____	_____	_____	_____	_____	_____	_____
○ **Measles**	**TD (tetanus/diphtheria)**	_____	_____	_____	_____	_____	_____	_____
○ **Chicken pox**	**Tetanus**	_____	_____	_____	_____	_____	_____	_____
○ **German measles**	**Polio**	_____	_____	_____	_____	_____	_____	
○ **Mumps**	**MMR**	_____	_____					
○ **Hepatitis**	**or Measles**	_____	_____					
	or Mumps	_____	_____					
TB Test	**or Rubella**	_____	_____					
Date of last test	**Haemophilus influenza B**	_____	_____	_____	_____			
_____								
Result: ○ **Positive** ○ **Negative**	**Hepatitis B**	_____	_____	_____				
	Varicella (chicken pox)	_____	_____					
	BCG	_____						

Allergies –List all known allergies(food, med, environment, etc.)describe reaction, and describe management of the reaction.

Medication allergies

Food allergies

All Other allergies

Medications being taken

Please list ALL medications, including over-the-counter or non-prescription drugs, taken routinely. Bring sufficient amounts of medication to last the entire time at the GSE. Keep it in the original package or bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. Medication will be dispensed by specific GSE personnel

Check one:

- ○ This person takes NO medications on a routine basis, or
- ○ This person takes medications as follows:

Med #1_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Med #2_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

(Attach additional pages for more medications.)

Special Dietary Needs--Please note special dietary needs here so that plans can be made with the food service

_____

_____

This health history is correct and complete as far as I know.

Parent/Guardian Signature	**Date**	**Student Signature**	**Date**

Final Checklist of items you are to send to

Elizabeth Vitullo, dean
Governor's School of Entrepreneurship
West Virginia University
College of Business & Economics
PO Box 6025
Morgantown, WV 26505

1. Signature Form	2. Include Insurance Card
3. Medical Information (2 pages)	4. List of special dietary needs