

*Brown University Simulation of the United Nations
Parent Release and Student Medical Information Form*

Participant's Name: _____
Last First Middle

Home Address: _____
Number/Street City State ZIP

Sex: M F **Birth Date:** ____ / ____ / ____

WAIVER of CLAIM / RELEASE FORM: This certifies that we, the undersigned parents/guardians, in consideration of the benefits to be derived by our above-named son/daughter (Participant), do certify that he/she may participate in any normal and routine training session or meeting of the Brown Model United Nations conference, the Brown University Simulation of the United Nations (BUSUN), and hereby release Brown Model United Nations, BUSUN, and Brown University from any and all claims resulting from any illness, injury, or accident incurred or suffered by said son/daughter while traveling to, attending, or participating in BUSUN.

MEDICAL and HOSPITAL SERVICES CONSENT: This certifies that we, the undersigned parents/guardians, in the event that our above-named son/daughter (Participant) becomes a participating member of the Brown University Simulation of the United Nations (BUSUN), do hereby consent and grant permission, should the necessity arise, for the furnishing of medical treatment and hospital services as ordered and recommended by a qualified physician, including the administration of an anesthetic, laboratory procedures, medical or surgical treatment, x-ray examination, or other hospital services. Consent is hereby granted to the attending physician(s), hospital(s), and/or clinics to release necessary medical information to our local doctors and for use in claims for insurance coverage.

WAIVER of PHYSICAL EXAMINATION STATEMENT: This certifies that we, the undersigned parents/guardians, understand our responsibility to fully inform the Brown Model United Nations and BUSUN staff of any and all medical precautions and to provide, attached hereto, any and all relevant medical records or information for use and reference by local physicians or medical personnel should the need arise.

Parent Release and Student Medical Information Form

Your Family Doctor: _____ **Doctor's Phone No.:** (____) ____ - _____

INSURANCE INFORMATION:

Our son/daughter is covered by health insurance: yes no

Insurance Company: _____ **Policy Number:** _____

Primary Card Holder's Name: _____

EMERGENCY CONTACT INFORMATION: Please provide information on where you can be reached 24 hours a day in the event of an emergency.

Parent/Guardian 1: _____ **Emergency Phone No.:** (____) ____ - _____

Parent/Guardian 2: _____ **Emergency Phone No.:** (____) ____ - _____

AUTHORIZED SIGNATURES: I/We certify that the information contained in this form is true and correct:

Parent 1 Signature and Date: _____

Parent 2 Signature and Date (Optional): _____