University of Massachusetts Boston

SUMMER TRANSPORTATION INSTITUTE II

Please type or print legibly using black ink. Only <u>completely filled out</u> applications will be considered.

STUDENT DATA

Last Name | First | M.I. | Date of Birth

Home Address | City | State | Zip Code

Email Address | Social Security Number | Age

Name of High School | Address | City/State | Zip Code

Name of Guidance Counselor | Telephone Number | E-Mail address

Gender: ☐Male □Female Which Summer Transportation Institute did you attend? _____ Year: _____

What grade are you in during the current School Year? ☐9th ☐10th ☐11th ☐12th

Awards/Achievements/Organizations (Attach additional sheet if necessary) _____

_____

Highest Math Completed_____ Grade Received_____ Overall GPA _____

I heard about the STI II Program through: □Internet □News Media □School □Parent □STI Other _____

PARENTAL/GUARDIAN DATA

Last Name of Mother, Father or Legal Guardian | First | M.I.

Home Address (If different from above) | City/State | Zip Code | Telephone Number

Occupation | Employer | E-Mail Address | Work Telephone Number

Required Essay: A typed, double-spaced 250-word essay entitled, "How did I apply what I learned from a Summer Transportation Institute."

Applications from students with disabilities are highly encouraged. Please describe any accommodations you may need:

Application checklist: (1) Enclose copy of Certificate of Completion from a Summer Transportation Institute, (2) one letter of recommendation, (3) school transcript, (4) essay, (5) most recent MA health form from your physician (within a year). (6) UMass Boston Youth Application Form. Incomplete applications will not be processed.

APPLICATION DEADLINE IS FC/FS **Submit applications by e-mail to tomas.materdey@umb.edu**	**For more information or assistance with this form, contact:**
Dr. Tomas Materdey **Summer Transportation Institute** **University of Massachusetts Boston** **100 Morrissey Blvd** **Boston, MA 02125-3393**	**Phone: 617-287-6431 or 6435** **Fax: 617-287-6053** **E-Mail: summer.institute at umb.edu or tomas.materdey at umb.edu**

Parent/Guardian's Signature | Date | Applicant's Signature | Date

University of Massachusetts Boston

Youth Program Application

2014

A copy of this publication is available in alternative format upon request.

APPLICATION INSTRUCTIONS

UMASS BOSTON

Participant's Name: _____

Program Name: _____ Date Submitted: _____

If you are applying to a youth program at the University of Massachusetts Boston, please complete and mail the following application packet to the address below:

_____ (Program Name)

University of Massachusetts Boston
100 Morrissey Boulevard
Boston, MA 02125

Failure to complete all forms in the application may result in your child not being accepted into the youth program.

- ☐ Policies and Guidelines – Pg. 3
- ☐ Personal, Family, and Emergency Contact Information – Pgs. 4-5
- ☐ Release Forms – Pg. 6
- ☐ Health History – Pg. 7
- ☐ Health Insurance Information – Pg. 7
- ☐ Healthcare Provider Signature – Pg. 8
- ☐ Immunizations – Pgs. 8-9
- ☐ Consent to Treat Minor Patient – Pg. 9
- ☐ Authorization to Administer Medication – Pg. 10

PERMISSION AND CERTIFICATION

I, the undersigned, hereby give my permission for my son/daughter to participate in all the activities of the _____ (insert program name) Program at UMass Boston from the date of his/her acceptance throughout his/her involvement with the program.
We (participant and I) agree to support the administrative rules of the _____ (insert program name) Program, the below referenced UMass Boston policies and guidelines, and to cooperate with the staff to our fullest extent.
Further, by signing below, I attest to the fact that all of the information provided by me or any other person on this application is true and complete to the best of my knowledge.

_____		
Signature of Parent/Guardian	**Printed Name**	**Date**

POLICIES AND GUIDELINES

PERMISSION TO PARTICIPATE When you signed your child's medical form, you gave permission for your child to participate in all program activities. If you wish for your child to be restricted from any activity, please notify us in writing prior to your child's program session. **Please note that it is not our policy to force any child to participate in an activity.** We do our best to make the activity enjoyable so your child will wish to participate.

MEDICAL CONCERNS All participants are required to have a completed application packet including UMass Boston's health history, immunizations, consent to treat minor patient, and authorization to administer medication forms on file before the program begins. Please be sure that you complete these forms and that your child's healthcare provider has signed that a physical examination has been conducted within the last 24 months. Please provide us with as much information as possible concerning your child's medical history, allergies, medications, and any special needs. All medical forms must include an up-to-date immunization record and must be signed by a healthcare provider. ***If these forms are not received at least 3 weeks prior to the program start date your child may not be allowed to start the program.***

MEDICATION Every effort should be made to administer routine medications at home in order to prevent disruption in your child's daily program activities. However, if your healthcare provider believes that it is in the best medical interest of your child to administer them during the program's hours, please submit the completed **Authorization to Administer Medication** form. A separate form must be completed for each medication. State law does not permit administration of medication during the program hours without written authority by the prescribing healthcare provider. Youth program participants are at no time allowed to carry any kind of medication, be administered medication without official written directive from the prescribing healthcare provider, or take medication without direct youth program supervision.

SAFETY PROCEDURES Whenever possible, we bring outdoor activities into air-conditioned facilities, or to cool, shaded areas. Our first concern is for your child's safety; therefore, we reserve the right to take the following actions in very hot weather: reduce physical activities, substitute outdoor activities for sedentary activities, and provide activities unrelated to your child's specialty (e.g., movies).

MEDICAL NOTIFICATION It is our policy to notify you if your child becomes ill during the youth program or suffers an injury other than minor bumps, bruises or scrapes.

VALUABLES We recommend that program participants not bring large sums of money or other valuables to UMass Boston. The University is not responsible for lost or stolen personal items.

SUNSCREEN The use of sunscreen is highly recommended by University Health Services. It is best to apply sunscreen to your child before he or she leaves home in the morning. You may wish to send along additional sunscreen to be applied later in the day.

INAPPROPRIATE BEHAVIOR UMass Boston reserves the right to dismiss any participant who acts in an inappropriate or detrimental manner including bullying, harassing, intimidating, or threatening to other individuals.

Signature of Parent/Guardian	**Printed Name**	**Date**

PERSONAL, FAMILY, AND EMERGENCY CONTACT INFORMATION

Name of Participant (first & last): _____

_____
Street Address **Apt. #**

_____
City **State** **Zip Code**

Participant's Cell Phone # (if applicable): _____

Participant's Date of Birth: _____ Participant's Gender: male_____ female_____

Name of School: _____ **Participant's Grade: _____**

Language Spoken at Home: _____ **Hair Color: _____**

Eye Color: _____ **Height: _____**

Weight: _____ **Can the participant swim? Yes_____ No_____**

Parent/Guardian Name (first & last): _____

_____
Street Address **Apt. #**

_____
City **State** **Zip Code**

Home Phone #: _____ **Work Phone #:_____**

Cell Phone #: _____

<u>Emergency Contact #1</u>

Name (first & last): _____

_____
Street Address **Apt. #**

_____
City **State** **Zip Code**

Home Phone #: _____ **Work Phone #: _____**

Cell Phone #: _____

Relationship to Participant: _____

Emergency Contact #2

Name (first & last): _____

_____

Street Address **Apt. #**

_____

City **State** **Zip Code**

Home Phone #: _____ **Work Phone #: _____**

Cell Phone #: _____

Relationship to Participant: _____

_____

Signature of Parent/Guardian **Printed Name** **Date**

RELEASE FORMS

PLEASE READ THE FOLLOWING RELEASES CAREFULLY AND PROVIDE A SIGNATURE FOR EACH SECTION BELOW.

GENERAL RELEASE

I, _____,(parent/guardian) as parent or legal guardian of _____ (participant's name), in consideration of my child being allowed to participate in the _____ (insert program name) Program, on behalf of my child, myself, my family, my heirs, representatives, assigns, executors or administrators, I hereby release and agree to hold UMass Boston, its trustees, directors, officers, employees, servants, representatives, agent licensees, successors and assigns, harmless from and against any and all claims, losses, damages, expenses (including attorneys' fees, and all court and litigation costs) and liability (including statutory liability), resulting from injury and/or death of any person or damage to or loss of any property arising out of or in any way from the _____ (insert program name) Program and my child's participation therein.

_____

Signature of Parent/Guardian **Printed Name** **Date**

RELEASE TO PARTICIPATE IN PROGRAM ACTIVITIES

I hereby give permission for my son/daughter to participate in all activities, including field trips in the youth programs including transportation to and from UMass Boston including program related activities from the date of his/her acceptance throughout his/her involvement with the program, and I hereby certify that the statements on this form are true to the best of my knowledge and belief. We further agree to support the administrative rules of the program and to cooperate with the staff to our fullest extent.

_____

Signature of Parent/Guardian **Printed Name** **Date**

MEDIA RELEASE

Beginning as of the date of execution of this release, that photographs, whether still or action, videos, film and/or motion pictures (hereinafter "Pictures") and/or audio recordings ("Recordings") may be taken of my child, individually or with others, by or on behalf of UMass Boston in connection with this youth program, and agree that all rights therein shall irrevocably, exclusively, unconditionally and perpetually belong to UMass Boston and that such rights are freely assignable by UMass Boston. I further agree that, without any compensation or notification to or approval by me, the Pictures or Recordings, and website postings may be used, reproduced or otherwise disseminated or published by or on behalf of UMass Boston directly or indirectly for any purpose, including but not limited to advertising and/or promotional purposes, in any manner, and at any time that UMass Boston desires. For good and valuable consideration, receipt of which is hereby acknowledged, I hereby agree to release and discharge UMass Boston, its trustees, directors, officers, employees, servants, representatives, agents, licensees, successors and assigns from any and all claims, demands or causes of action that I may now have or may hereafter have for libel, defamation, invasion of privacy or right of publicity, infringement of copyright or violation of any other right arising out of or relating to any utilization of the Pictures or Recordings.

_____

Signature of Parent/Guardian **Printed Name** **Date**

HEALTH HISTORY

AS A YOUTH PARTICIPANT, PARENT OR GUARDIAN I UNDERSTAND THAT: The information requested on this form is intended to help inform staff of any pre-existing medical conditions. If your child has a pre-existing medical condition, **participation in any strenuous activities or recreational time may not be recommended. *This information will be kept in strict confidence and will only be shared with your permission*.** UMass Boston requests the information below so that, in case of emergency, we will have accurate information so that we can provide and/or seek appropriate treatment. You are accountable for providing an accurate medical history. ***Final determination about whether to participate is the responsibility of UMass Boston's consulting health care provider***. If you have any medical issue that is not requested below, but which you think is important, please include that information.

(To be completed by Parent/Guardian)

Name of Participant (first & last): _____

Has the participant had, or does the participant have, any of the following? Circle "Y" for Yes and "N" for No. (If yes, please explain on separate sheet of paper)

Y	N	Heart disease/ heart defect	Y	N	Asthma
Y	N	High blood pressure	Y	N	Easy Bleeding
Y	N	Seizures/epilepsy/fainting spells	Y	N	Emotional/psychiatric/behavioral issues
Y	N	Diabetes	Y	N	Sickle cell trait or disease
Y	N	Concussion or serious head injury	Y	N	Food allergies or special diet
Y	N	Heat stroke/exhaustion	Y	N	Other allergies
Y	N	Contact lenses/glasses			

Y N Any limitations that restrict running, swimming, participating in group recreational activities? If yes, please explain on a separate sheet of paper

Will the youth need to take any medications during program hours? Yes_____ No_____

If yes, provide instructions here:

_____

Are you pregnant? (females only) Yes_____ No_____
If so, my estimated due date is:_____

Use this space to provide any additional information on the youth's physical health about which the youth program at UMass Boston should be aware:

_____

_____

PLEASE READ: As a participant, parent or guardian I understand and acknowledge that my failure to disclose relevant information may result in dismissal from a UMass Boston-Summer Youth Program. By signing my name I represent and warrant that I have provided all materials and important information to UMass Boston pertaining to my child's medical, mental and physical condition and that it is accurate and compete. I agree to notify the program nurse of any changes in my mental, physical or medical condition prior to my Child's scheduled program.

_____

Signature of Parent/Guardian **Printed Name** **Date**

HEALTH INSURANCE INFORMATION

Please include a copy of your child's health insurance card. If you cannot provide the requested health insurance card; please provide the following insurance information:

_____

Insurance Carrier Policy Number

_____

Cardholder's Name

HEALTHCARE PROVIDER SIGNATURE

If you are unable to have a healthcare provider (physician, nurse practitioner, physician assistant) sign this form, you may submit a copy of a school physical form signed by a healthcare provider instead. **The physical must have occurred within the last twenty four (24) months.**

TO BE COMPLETED BY A HEALTHCARE PROVIDER

_____ is physically able to participate in a general/sport program designed for participants with and without disabilities and his/her immunizations are up to date.

Comments/Limitations:

_____

_____

_____

Healthcare Provider Signature **Printed Name** **Date**

IMMUNIZATIONS

The following immunizations are required of all participants before attending our programs.

MEASLES, MUMPS AND RUBELLA (MMR) VACCINE
First dose must be after age 12 months; **2 doses required.**

POLIO VACCINE
A minimum of three doses of either inactivated polio vaccine (IPV) or oral polio vaccine (OPV) are required. If a mix of (IVP/OPV) was used, **four doses are required.**

DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE
Minimum of four doses of DTaP/DTP/DT or at least three doses of Td is required. A booster dose of Td is required for all program participants who will be entering grades seven through 10. For participants who will be entering grades 11 and 12, a booster of Td is required if it has been more than 10 years since the last dose of DTaP/DTP/DT/Td. (Tdap is also acceptable.)

HEPATITIS B
Three doses of Hepatitis B vaccine are required if born on or after Jan. 1, 1992.

EXCEPTIONS
If claiming a religious or medical objection, please attach information.

Please have your child's medical provider fill out the form on the next page or provide an official record on office letterhead from the provider's office. An official school record is also acceptable.

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / / **Sex:** □**female** □**male**

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		**Other:**		
	3				
	4				

Serologic Proof of Immunity		**Check One**	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox. **Date of chickenpox:** ___/___/____

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Medical Provider name (print): _____ ***Date:*** _____

Signature:_____

Address: _____ **Phone:** _____

CONSENT TO TREAT MINOR PATIENTS

Your child has been accepted to a youth program at the University of Massachusetts Boston. University Health Services offers first aid to minors who are participating in university sponsored youth programs. Massachusetts law requires consent of a parent/legal guardian for medical care of minors, including first aid. Please complete the following consent form to allow University Health Services to provide first aid to your child.

I, _____ (*print name here*), am the parent/legal

guardian of _____ (*print name of participant*), currently a

minor, whose date of birth is _____/_____/_____. I authorize the University of Massachusetts Boston

Health Services to provide first aid to the youth.

I understand that, should my minor participant need more extensive medical care I will be notified by a healthcare provider through University Health Services. I also understand that if the injury/illness is determined to be life threatening or require immediate medical attention beyond first aid, that an ambulance will be called to take my child to the hospital and that the provider will make every effort to contact me.

By signing this, I acknowledge that I have read and that I understand this consent, and that any questions that I have prior to signing could be answered by calling University Health Services at (617) 287-5660.

_____

Signature of Parent/Guardian **Printed Name** **Date**

PARENT/GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR OVER-THE-COUNTER MEDICATION

Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the camper's parent or guardian. Please complete the following section to save time if your child needs any of these OTC medications during his/her stay. Note: Unless we have parental authorization, we cannot administer ANY medications.

I hereby authorize that the following medications may be given to _____ (Child's Name) if the need arises. You may dispense only those checked.

____ Acetaminophen

____Benadryl

____Calamine Lotion

____Ibuprofen

____Triple Antibiotic Ointment

____Hydrocortisone Ointment

The following Medication can be administered to summer youth participants following emergency medication specific protocol.

____ Acetaminophen

____Albuterol Sulfate Inhalation Solution

____ Tylenol/Acetaminophen as directed.

____Albuterol Inhaler

____Epi-Pen Jr. or Epi-Pen

I understand that such administration will be done under the supervision of medical personnel.

Any condition which is associated with fever, significant inflammation, and/or does not respond to the above outlined treatment will be followed-up by a consultation with the youth's parents. Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I authorize the administration of over-the-counter medications to my child as indicated above.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Appendix G-4

AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION

Please provide separate sheets for each medication.

A.) TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that _____ (participant's name) receive the medication as prescribed below by our licensed healthcare provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the R.N. or other licensed healthcare provider will administer the medication.

_____

Signature of Parent/Guardian **Printed Name** **Date**

B.) TO BE COMPLETED BY THE LICENSED PRESCRIBER:

I request that my patient, as listed below, receive the following medication:

Name of participant: _____ Date of Birth: _____/_____/_____

Diagnosis: _____

Name of medication: _____

Prescribed dosage, frequency and route of administration:

_____

Time to be taken during program hours: _____

Duration of treatment: _____

Possible side effects and adverse reactions (if any):

_____

Other recommendations: _____

Name of licensed prescriber and title (please print):

_____

_____

Street Address **Apt. #**

_____

City **State** **Zip Code**

_____

Signature of licensed prescriber **Printed Name** **Date**