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| **Girls Go Med Day Application** | | | |
| The event will take place **Saturday,** **April 21, 2018** from 9 a.m. to 3 p.m. at Northeast Ohio Medical University (NEOMED). Registration will be from 9:00-9:30 am. Applications are being accepted on a first come first serve basis and must be postmarked or emailed in by no later than **March 21, 2018.** | | | |
| Student Information | | | |
| Name: | | | |
| Date of Birth: | | Phone: | |
| Current Address: | | | |
| City: | | State: | Zip Code: |
| E-mail: | | | |
| Current School: | | | Grade: |
| Food Restrictions/Allergies (note – a variety of Subway sandwiches will be provided): | | | |
| T-Shirt Size (circle one): XS S M L XL | | | |
| Payment Information | | | |
| Payment form: ￼Check and NUMBER:  Please make checks payable to: NEOMED AMWA  *The program fee is* ***$40.*** *Please contact a program coordinator for information on registration fee waivers. Waivers are given based on financial needs.* | | | |
| Parent/Guardian Information | | | |
| Name: | | | |
| Phone: | | | |
| Current Address:  *same as address above* | | | |
| City: | State: | | Zip Code: |
| E-mail: | | | |
| Parent/Guardian Signature: | | | |
| Pick up information: List the individuals given permission to pick your child up or write “I will be driving myself” | | | |
|  | | | |

*Parents/Guardians will be required to present photo identification in order to pick up their child.*

For questions or more information,

please contact a program coordinator:

AMWA Board (amwa@neomed.edu)

Geetika Srivastava (gstrivastava@neomed.edu)

Priya Singh (psingh7@neomed.edu)

Jasmine Binod (jbinod@neomed.edu)

Submit forms to:

Northeast Ohio Medical University

Office of Student Affairs

Attn: Harmony Stanger

4209 St. Rt. 44 P.O. Box 95

Rootstown, OH 44272



SCREENING PROGRAM CONSENT AND RELEASE

As a community member participant involved with the Northeast Ohio Medical University (NEOMED) **American Medical Women’s Association** sponsored health screening event **Girls Go Med Day**, you hereby voluntarily consent that NEOMED medicine and pharmacy students should conduct the particular health screenings marked below to allow you to acquire more information about your personal health. At any time during your health screening, you may choose to end your involvement. You may have your finger stuck with a needle as part of your health screening and you acknowledge that a slight risk of an infection or bruising to your finger may exist. You acknowledge that NEOMED has provided you with the opportunity to ask questions and have them answered.

Blood Pressure Measurement  Glaucoma Screening

Blood Glucose Screening  Vision Screening

Blood Cholesterol Screening  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You acknowledge that the health screenings performed by NEOMED are for informational purposes only. You may be sharing some health information with NEOMED to aid the screening process, but NEOMED will not retain or maintain that information in any format, except for information that is not personally identifiable to you which may be used for research and statistical purposes.

The health screenings will not provide conclusive or diagnostic information. You understand that no treatment will be offered or provided by NEOMED as a result of the findings of the screening examination performed. You will need to follow-up with your primary healthcare provider to discuss the results of your health screenings. If you do not have a primary healthcare provider, you may call Summa’s Physician Referral line at 330.379.5111.

You acknowledge that you assume the risk of any injury from your participation in the health screenings. In consideration of the screening examination to be performed by NEOMED, you agree to release, forever discharge and indemnify and hold harmless, NEOMED, its affiliates, its officers, employees, and agents, from and against all liabilities, obligations, losses, claims, causes of actions, demands, judgments, awards, costs and expenses, whether known or unknown and whether at law or in equity, including attorneys’ fees and expenses, resulting from any claim or demand arising from or connected with your participation in any health screening.

You acknowledge that you have read this Consent and Release in its entirety or that it has been read to you if you are unable to read it and that you understand its contents. You have voluntarily signed this Consent and Release and you hereby agree to the performance of all testing procedures as explained by NEOMED personnel.

**Participant Name (printed**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant Name (signature)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Screener (printed/signed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Screener (printed/signed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Faculty Advisor (printed/signed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Faculty Advisor (printed/signed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**RELEASE AND CONSENT TO PARTICIPATE**

I/We, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print names) are the parent(s) or legal guardian(s) with the authority to Release and Consent to Participate on behalf of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“Child”). I/We each understand and acknowledge that my/our Child will be attending **AMWA Girls Go Med Day**, a supervised educational program on the campus of the Northeast Ohio Medical University (“the University”). I/We further understand my/our Child will be on a college-level campus with exposure to college-level students and others from the public. I/We further understand and acknowledge that, as a part of the educational program, my/our Child may be engaged in activities on campus that may result in injury or harm, that may be mental, physical or emotional. By signing below, I release NEOMED (and its governing board, employees, and agents) from any and all liability, claims and actions that may arise from injury or harm to my Child or their property in connection with this activity. I recognize that this Release means I am giving up for myself and my Child among other things, rights to sue NEOMED, its governing board, employees, and agents for injuries, damages, or losses my Child may incur. I also understand that this Release binds me and my Child and her heirs, executors, administrators, and assigns. I/We also understand that participation in this educational program is entirely voluntary and requires my/our Child to abide by applicable rules and standards of conduct for the University.

**Signatures:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent or Guardian)

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent or Guardian)



**Authorization and Consent to Photograph, Record and Publish**

I hereby grant to Northeast Ohio Medical University (the University) the following rights in the interest of furthering the University’s creation and distribution of educational, information al, clinical, artistic or other materials:

1. The right to record my image, photograph, picture, likeness, and voice by any technology or means.

2. The right to copy, use, perform, display and distribute such recordings of me for any legitimate purpose, including but not limited to distribution by means of streaming or other technologies via the Internet, or distribution of audio or video files (e.g. podcasts) for download by the public.

3. The right to combine such recordings of me with other images, recordings, or printed matter in the production of motion pictures, television tape, video streaming, sound recordings, still photography, CD-ROM or any other media.

4. The right to record, reproduce, amplify and simulate my image and all sound effects produced.

5. The right to assign, transfer, or license the above rights to third parties.

6. The right to use my image and voice in connection with the marketing of the University’s programs, events, or educational, artistic, or other materials.

I have entered into this Agreement in order to assist the University in its mission of teaching, research, clinical care and public service and I hereby waive any right to compensation, now or in the future, in connection with the University’s exercise of the rights granted hereunder.

I hereby assign to the University any and all copyright I may have in the recordings made of me hereunder.

I hereby hold harmless and release and forever discharge the University, its officers, employees and agents, either in their individual capacities or by reason of their relationship to the University and its successors or the State of Ohio and all of its employees or agents from all claims and demands whatsoever that I or any other persons acting on my behalf or on the behalf of my estate have or may have against the University or any or all of the above-mentioned persons or their successors or the State of Ohio by reason of the above-mentioned grant of permission, including all claims for libel and invasion of privacy or infringement of rights of copyright and publicity.

I state that I am at least eighteen (18) years of age and am competent to contract in my name. (If not 18, must have the signature of a parent or guardian.) I have read and fully understand the above.

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

Signature of Person Granting Consent Date

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

Printed Name of Person Granting Consent

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

Address Phone Number

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City State/Country Zip Code

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Signature of Parent/Guardian of Minor Date

If you have any questions, please contact the University’s Office of Public Relations at 330-325-6618.