HIGH SCHOOL PARTICIPANT (independent)
SUPERVISED LABORATORY RESEARCH

PARENTAL CONSENT FORM

Student's Name: ____
(please print clearly)

I am the parent (guardian) of the above-named student who wishes to participate in supervised laboratory research at the State University of New York at Stony Brook this summer.

I fully understand that, although every safety precaution will be taken, certain risks of physical injury and/or property damage always potentially exist in such a program.

I understand that SUNY at Stony Brook does not provide insurance in these cases, and that the primary responsibility in case of an accident will be provided by myself.

It is my intention in signing this statement to grant permission to SUNY at Stony Brook to allow my child to participate in laboratory research this summer.

Name of parent or guardian:____

Address: ____
street city

____
home phone work phone

Student's school:____
phone

Emergency contact information:
In the event that I cannot be reached with reasonable effort, I hereby authorize the following adult to act in my stead in non-medical decisions and actions regarding my child/ward while participating in supervised laboratory research.

Contact adult: ______________________Relationship:______________________

Phone Number: ______________________Address:______________________

______________________ ______________________
(Signature of Parent or Guardian) Date

**** Please return this form to the student's faculty supervisor.*

MEDICAL RECORD FORM FOR STUDENT

STUDENT NAME ____

In order that we may be aware of any particular medical problem while your child is participating in laboratory research at Stony Brook, please complete the following:

Does your child suffer or has your child suffered from:

__________ Allergies (explain in other)
__________ Asthma or other chest or lung problem
__________ Bone & Joint problems
__________ Cancer
__________ Diabetes
__________ Epilepsy
__________ Headaches
__________ Hearing problems
__________ Heart problem
__________ Hepatitis
__________ High Blood Pressure
__________ Stomach problems
__________ Kidney or Urinary problems
__________ Thyroid problems
__________ Other – please indicate: ____

____

Is your son/daughter taking any medication on a regular basis? ____ YES ____ NO

If so, medication used ___________________________________ How frequently? _____________________

For what condition? ____________________________________

Additional Comments

____

Name of Family Doctor ______________________________ Address________________________________

Phone _________________________________ ________________________________

Date of child's last physical _________________________________
(Please send copy of the last physical with this form.)

MEDICAL INSURANCE INFORMATION

Type of coverage (Blue Cross, Empire, GHI, etc.) ____

Name of Insured (Parent/Guardian) ____

Group # _____________________ Additional Information ____

If Medicaid coverage, give case # ______________________________ Person I.D. # ____________________

If no medical coverage, check here □

IMMUNIZATIONS:

**** Please return this form to the student's faculty supervisor.*