Airways Biology Initiative Summer Research Program

ABI Summer Research Program
University of Pennsylvania
125 South 31st Street Suite 1300
Philadelphia, Pa. 19104-3413

Phone: (215) 573-9874
Fax: (215) 746-1224
http://www.med.upenn.edu/airways/

PARENTAL CONSENT STATEMENT & INSURANCE DOCUMENTATION FORM

As the undersigned parent/guardian of _____,
Print Minor Student's Full First and Last Name

I understand and consent as follows:

My child has been offered a summer volunteer position at the University of Pennsylvania in the Airways Biology Initiative for educational/training purposes, from the third week of June until the second week of August.

I understand that my child will not be supervised or mentored during non-internship hours during his/her stay in the Philadelphia area and that the University of Pennsylvania is not responsible for their travel expenses or any housing/living expenses.

I understand that laboratories are specialized environments in which chemicals, biological materials, and special instruments are often used, and can have the potential for creating hazardous conditions. I am aware of the potential for such risk, and I agree to my child's volunteering in the Airways Biology Initiative Summer Research Program.

In the event of any emergency occurring during my child's summer volunteer experience, I grant permission to the University of Pennsylvania, its physicians, members of the faculty, agents and/or employees to provide such emergency care and treatment that in their judgment may be deemed medically necessary or advisable. I agree to cover the cost of such emergency care/treatment, if any is needed, as well as, any subsequent treatment or care my child might require.

Name of Parent/Guardian: (Please print full name) _____

Signed: _____Signed (witness): _____

Date: _____ Date: _____

Insurance Information (please submit a photocopy of insurance card, front and back)

Insurance Carrier: _____Carrier Group Num: _____

Policy Holder's Name: _____Policy Holder's ID #: _____

If applicable, Insurance Carrier pre-certification telephone number: _____

Address for claim submission: _____

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Medical Emergency Contact Information

Person to contact first:
Name: _____
Relationship: _____
Day Tel: _____
Mobile: _____
Eve Tel: _____

Person to contact second:
Name: _____
Relationship: _____
Day Tel: _____
Mobile: _____
Eve Tel: _____

Person to contact third:
Name: _____
Relationship: _____
Day Tel: _____
Mobile: _____
Eve Tel: _____