Permission and Medical Release Forms / Permiso y Autorización Médica

I, the parent or legal guardian of____________________________, will not hold Bluegrass Community and Technical College, partner organizations nor their members, employees or volunteers responsible for any accident or injury incurred by the named youth participant above while he/she is participating in any activity sponsored during this college preparation camp or while being transported to and from any activity sponsored by the camp. This agreement and medical information will be valid from this point on or until the parent or legal guardian of the named youth change it in writing and is received by the host institution of such events or activities.

Signature of parent or legal guardian/ Firma de padre de familia o tutor legal:		Date/Fecha	
Signature of Witness/Testigo:		Date/Fecha	

Yo, el padre o tutor legal de________________________________, no hago responsables a Bluegrass Community and Technical College, organizaciones collaboradores, ni a sus miembros, a sus empleados y a sus voluntarios, por ningún accidente ni herida sufrida por el joven nombrado aquí mientras esté participando en cualquier actividad auspiciada o facilitada por BCTC ni mientras el campamento de preparación universitaria. Ni tampoco les hago responsables por ningún accidente mientras el transporte, que sea de ida y vuelta de cualquier actividad auspiciada o facilitada por la administración del campamento. Esta disposición estará vigente hasta que los padres de familia o el tutor legal del joven nombrado anteriormente la cambien en escrito y sea recibida por la institución auspiciadora o facilitadora de tales eventos o actividades.

If a medical emergency occurs, we, the staff of the Latino Leadership and College Experience Camp of Bluegrass Community and Technical College, parnter organizations and our partners will make every possible effort to contact the parents or legal guardian of the student in order to approve any medical treatment needed due to the emergency. We ask you sign this permission form so that we can treat or provide medical services to your child, in the event we are not able to locate the parent or legal guardian.

This is to certify to all the medical staff that I, the parent or legal guardian of______________________________, through this form gives authorization and consent to give emergency medical treatment to the above named youth and that we assume responsibility for all expenses incurred for the said emergency medical services.

Si ocurre una emergencia médica, nosotros, el personal del Programa de Preparación Universitaria de Bluegrass Community and Technical College, partner organizations y nuestros asocios hará todo lo posible para ponerse en contacto con los padres de familia o con el tutor legal del estudiante para que aprueban el tratamiento de emergencia. En caso que no podamos localizarlos, les pedimos que firmen este permiso para el tratamiento de emergencia.

Esto es para certificar a todo el personal médico que soy el padre legal o tutor legal de______________________, y que por medio de este formulario doy mi autorización y consiento a todos que se le den servicios de emergencia al joven nombrado anteriormente y que asumo responsabilidad total de los gastos incurridos debido a dicho servicio médico de emergencia.

Signature of parent or legal guardian/ Firma de padre de familia o tutor legal:		Date/Fecha	
Signature of Witness/Testigo:		Date/Fecha	

Medical Information/ Información médica

Do you have any food or medical allergies? If so, please describe.

¿Tienes alergias a comidas o medicinas? ¿Y, si es así, descríbelas a continuación?

____

____

Do you take any medications? If so, please provide type of medicine, dosage and frequency.

¿Tomas medicinas? Y, si es así, favor de elaborar detalladamente los nombres de ellas, la dosis y la frecuencia con que las tomas.

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Name of doctor or clinic of choice / Nombre del médico o clínica preferidos.

____

Telephone Number / Telefono:____

Emergency Contact Information/ Información de contacto en el caso de emergencia:

Name/Nombre:______________________________Teléfono/ Phone #: _____________________________________

Address/Domicilio:____

Relationship/Parentesco: ____

Does the participant have any physical or emotional limitations or concerns that of which staff should be aware?
¿Tiene el/la participante alguna limitación o preocupación física o emocional de la cual los directores deben saber?

____

____

____

Kentucky Community and Technical College System
Excess Insurance for Camps/Conferences/Field Trips
Summary of Coverage

Insurance Carrier Ash Group (Axis Global)

Coverage Insurance coverage is on an **excess** basis only. The participants' personal health insurance policy will be primary and provide coverage for accident. The **excess** policy will cover any out-of-pocket expense not paid by the participants' personal insurance up to the limits of the policy listed below. (This includes payment of the deductible and coinsurance amounts if applied under the participants' personal policy.) The benefit period is 52 weeks from the date of an injury. The first expense must be incurred within 90 days of the accident and care is medically necessary. If the participant does not have personal health insurance coverage, this **excess** policy will pay first dollar, up to the limits of this policy. Pre-existing conditions are not covered. A pre-existing condition is any condition for which a prudent person should have sought treatment or was treated in the previous six months.

Coverage Benefits & Limits

Accident Medical Expense (**Excess**)	$25,000
Accident Dental Expense (**Excess**)	URC*
Physical Therapy	URC*
Deductible	None
AD&D Principle Sum	$15,000

*UC = Usual & Customary

Consent to Medical Treatment/Insurance Statement

It is understood that authority is given to the Kentucky Community and Technical College System, or anyone they may designate, to have my son/daughter treated for injuries they incur during a designated camp, conference, or field trip activity with the college.

I understand that I will be notified if a health problem arises, but in the event I cannot be reached by telephone, I hereby give KCTCS, or anyone they may designate, permission to seek medical treatment for the participant named below, including surgery (on an emergency basis) or additional advanced treatments (MRI, lab tests, etc.) as deemed necessary by competent medical personnel.

I am aware that, as the adult participant, or as the parent or legal guardian of the participant named below, I will be responsible for any expenses incurred outside of the limits provided by the Kentucky Community and Technical College System's Camps/Conferences/Field Trips Policy. I also understand that the System insurance coverage is on an "excess" basis only. The excess policy will cover any out-of-pocket expense not paid by the participant's personal insurance up to the limits of the policy listed above.

____ ________________________________

Date Name of Participant Signature (Parent or Guardian if claimant is a minor)

Emergency Contact (if other than parent) Name:____________________________________

____

Phone

FORM FM 92 **08/25/2005**

Kentucky Community and Technical College System
Camps, Conferences & Field Trips
Medical Insurance Information Form

Participant Name:____
Last First Middle

Address:____
Street Apt.#

____
City State Zip Code

Participant's Social Security No. (optional):______________________
Age:________________Date of Birth:______________________
Parent/Guardian Name(s):______________________________
Business phone:mother:______________ step mother:______________
father:______________ step father:______________
Home phone mother:______________ step mother:______________
father:______________ step father:______________
Neighbor or Relative (Other than parent/guardian): Phone:______________

Primary Insurance Information

Parent's Insurance Covering Participant

Insured:______________________ Date of Birth:______________

Policy Number:__________________ Member ID #:______________

Insurance Co.:__________________ Phone #:________________

Insurance Co. Address:__________________________________

Second Parent's Insurance (if participant is also covered under this policy)

Insured:______________________ Date of Birth:______________

Policy Number:__________________ Member ID #:______________

Insurance Co.:__________________ Phone #:________________

Insurance Co. Address:__________________________________

Check and sign if participant has no health coverage. There is no health insurance coverage for this participant at this time.

Signature Parent/Guardian______________________ ___Date:________

PH●T● AND MULTIMEDIA RELEASE F●RM

I agree that my likeness may be used for BCTC and LLCEC purposes including but not limited to magazine articles, web features, national and regional advertising on TV, online, radio, newspapers, outdoor properties and grant and funding reports.

Event: LLCEC 2021 ________________________ Date: July 2021 ______

Name	**Signature**	Paren, Signarure *(if under 18)*
____________	____________	________________
____________	____________	________________

500 Newtown Pike, Lexington, KY 40508