Rutgers Institute for Translational Medicine and Science

RITMS Summer Research Program
Rutgers, the State University of New Jersey
Child Health Institute of New Jersey
89 French Street, Suite 4211
New Brunswick, NJ 08901

Phone: (732) 235-5207
Fax: (732) 235-7178

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 Rutgers University in the Rutgers Institute for Translational Medicine and Science 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 New Brunswick area and that the Rutgers University 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 Rutgers Institute for Translational Medicine and Science Summer Research Program.

In the event of any emergency occurring during my child's summer volunteer experience, I grant permission to the Rutgers University, 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 Number: _____

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: _____