Cascades East
Area Health Education Center

DIAGNOSIS DAY acknowledgments and permissions. Each student is to complete all highlighted areas. If the student is under 18, parent/guardian signatures are required. Please bring completed forms to DIAGNOSIS DAY. This form is in addition to the on-line registration form for DIAGNOSIS DAY.

STUDENT NAME: _____ **SCHOOL** _____

Please print clearly- first name, last name

Date of Diagnosis Day program: _____

Emergency contact information and health insurance liability acknowledgement:

Emergency contact name _____ **Relationship to student** _____

Day phone _____ **Evening phone** _____

_____ _____ _____

Address **City** **Zip**

As parent/guardian of the student, I acknowledge that medical insurance is my responsibility _____

Parent/guardian signature

PERMISSION FOR USE OF PHOTOGRAPHY and QUOTATIONS

I grant Cascades East AHEC at St. Charles Health System permission to use finished photographs or video(s) and quotes of said person for purposes of program development, education, and/or program promotion. I further grant the Cascades East AHEC at St. Charles Health System the right to publish and/or publicly exhibit the photograph(s), slide(s), or video(s), online social networking and quotes in any lawful and legitimate manner for the purpose set out above.

_____ student or parent initials