

# 2008 SPACE VOYAGE ACADEMY – RELEASE AND MEDICAL AUTHORIZATION

MAIL TO: SPACE VOYAGE ACADEMY, 1504 SOUTH JOHNSON COURT, LAKEWOOD, CO 80232  
PHONE: 303-985-3143 Web Site: <http://www.spacevoyage.com>

CAMP LOCATION: Space Voyage Academy at Summit Ridge Middle School  
11809 West Coal Mine Ave., Littleton, CO 80127

Student's Name: \_\_\_\_\_ Space Voyage Academy Attending Dates: \_\_\_\_\_

With whom will this child be living at the time of the camp? Parents \_\_\_\_\_ Other \_\_\_\_\_ (please specify)

Father/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Please use the following space to explain any special instructions/circumstances the academy staff should be aware of regarding the health of your child.

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### RELEASE OF LIABILITY

In consideration of Space Voyage Simulations and Space Voyage Academy at granting the above named student permission to participate in the academy, I hereby assume all risks of his/her personal injury (including death) that may result from any activity at Space Voyage Academy. As parent/guardian, I do indemnify, defend and hold harmless, Space Voyage Academy, Jefferson County Public Schools, Space Voyage Simulations, its officers, employees, agents, instructors, and all participants in the academy program from all liability, including claims and suits at law or in equity, for injury, fatal or otherwise, which may result from negligence and/or the student taking part in program activities.

### PHYSICAL EXAMINATION WITHIN ONE YEAR

I certify that within the past year my daughter/son has had a physical examination by a physician, and he/she is physically able to participate in the Space Voyage Academy activities.

### CONSENT FOR TREATMENT AND/OR FIRST AID

In the event of injury or illness, I hereby give my consent for medical treatment and permission for first aid to be provided on site for minor injuries, and permission to secure proper treatment for my child as deemed necessary. I understand every attempt will be made to contact me, the parent/guardian, prior to any medical attention beyond minor first aid, is given.

### RELEASE OF MEDICAL INFORMATION

I authorize the release of medical information for billing purposes.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE RETURN THIS FORM ALONG WITH THE SVA MEDICAL FORM TO SPACE VOYAGE. REGISTRATION WILL NOT BE FINAL UNTIL THIS FORM IS COMPLETE AND ON FILE WITH THE PROGRAM. PLEASE MAIL TO SPACE VOYAGE, 1504 SOUTH JOHNSON COURT, LAKEWOOD, CO 80232.