U.S. DEPARTMENT OF ENERGY
2024 TENNESSEE SCIENCE BOWL
UNDERAGE VOLUNTEER PARTICIPATION FORM

Volunteer Name: ________________________________ Age: _____________________________________

1. PARENTAL CONSENT: I, (Mr., Mrs., Ms.) ____, the parent or legal guardian, as appropriate, of ________________________________, give my consent for him/her to participate as a volunteer helping with activities associated with the Department of Energy (DOE) 2024 Tennessee Science Bowl competition.

2. MEDIA RELEASE: To promote, evaluate, or otherwise describe the DOE's training and educational programs and activities, I give permission to the Department, its agents, ORAU, and the Oak Ridge Institute for Science and Education (ORISE) to photograph my child and/or obtain interviews during the 2024 Tennessee on February 23-24, 2024 and to use in connection with any publication (including but not limited to brochures, booklets, videotapes, reports, press releases, Web sites, and exhibits) any image or recording in which my child, a minor, appears, to use and cite any comment(s), verbal or written, made by said minor about the program, and to use said minor's name in connection with any publication and in such manner as determined by the DOE, ORAU, or ORISE.

3. LIABILITY RELEASE: I hereby release and discharge the DOE, ORAU, ORISE, the United States Government, their officers, agents, servants, and employees, and persons, firms, or corporations contracting with, or acting on behalf of, the DOE or the United States Government with respect to all activities associated with the DOE 2024 Tennessee Science Bowl competition, as well as their heirs, executors, administrators, successors, or assigns, from any cause of action of any nature whatsoever arising from my child's participation in any and all activities associated with the DOE 2024 Tennessee Science Bowl competition.

STUDENT CONFIDENTIAL MEDICAL INFORMATION AND EMERGENCY NOTIFICATION INFORMATION

Chronic Medical Conditions: ____

Allergies (including food): ____

Current Medications: ____

Emergency Contact Name: ______________________________ Phone Number: __________________________

Alternate Phone Number: _______________________

Health Insurance Carrier: __________________________________ Policy Number: ________________________

Name of Policy Holder: __________________________________ Carrier Phone Number: __________________

4. MEDICAL TREATMENT AUTHORIZATION: I hereby authorize and consent to the administration of all medical and/or surgical treatment(s) to my child by a licensed physician, nurse or hospital in the event I am not available to consult with the attending physician(s), attempts to contact me have been unsuccessful, and the attending physician(s) deem it advisable to proceed with such treatment(s). *(Parental consent is required before a hospital's emergency department can give medical treatment to a minor. Every effort will be made to contact parents, but a completed consent form will expedite treatment.*)

____ Volunteer Date of Birth: ___________________
(Print Name of Parent or Legal Guardian)

____ Date: _______________________
(Signature of Parent or Legal Guardian)