

**U.S. DEPARTMENT OF ENERGY
2025 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) 2025 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 2025 Tennessee on February 21-22, 2025 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 2025 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 2025 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.)*

(Print Name of Parent or Legal Guardian)

Volunteer Date of Birth: _____

(Signature of Parent or Legal Guardian)

Date: _____