CONTINUING EDUCATION
THE UNIVERSITY OF TEXAS ARLINGTON

Kids and Teens University Required Forms Instructions

<u>The following forms are included in your Kids and Teens University packet</u>:

Kids and Teens University Camp Guidelines - Please keep these forms for your records

Kids and Teens University Camp Registration Form (Required – Please complete and return)
Complete all sections of the registration form by indicating which camp you would like for your child to attend

Notice of Privacy Practices – Please keep these forms for your records

Notice of Privacy Practices – Acknowledgement of Receipt Form (Required - Please complete and return)
Complete the following sections of the Acknowledgement of Receipt Form
Print Patient/Visitor Name (put your child's name in this section)
Date of Birth (put your child's Date of Birth in this section)
Gender (put your child's Gender in this section)
Parent/Guardian Signature (please sign your name in this section)
Date (please include the date you sign the form in this section)
Leave all remaining section of the Acknowledgement of Receipt Form blank

Consent for Treatment of a Minor Who Does Not Have Legal Power to Consent
(Required - Please complete and return)
Complete all sections of the Consent to Treat and Medical Information Form
Sign the signature section in the middle of the form

Release and Indemnification Agreement for Minors (Required - Please sign and return)

Photographic Consent and Release Form (optional)
See form – If you do not want your child's picture taken please indicate that in writing

Kids and Teens University Authorized Person(s) Pick-up Form (Required - Please complete and return)
Complete all sections of the Authorized Person(s) Pick-up Form

Kids and Teens University Forms Checklist

UT ARLINGTON DIVISION FOR ENTERPRISE DEVELOPMENT

Kids and Teens University Summer Class Registration Form

Child's Last Name: _____

Child's First Name: _____

Address: _____

City: _____ Zip: _____

Phone: _____

Parent's name: _____

Parent's email: _____

Has your child attended a Kids and Teens University Camp Before: ◯Yes ◯No

What School Does your Child Attend?_____

What's Your Child's Grade Level? ☐1 ☐2 ☐3

T-shirt size: (Child Size) ☐S (6-8) ☐M (10-12) ☐L (14-16) or
(Adult size) ☐S ☐M ☐L ☐XL ☐2X

June 8, 2015-June 12, 2015 Monday-Friday 9:00 AM – 12:00 Noon

Grades 1 - 3

☐ LEGO® Dino Camp Fee: $209

☐ LEGO® Robotics Fee: $209

June 15, 2015-June 19, 2015 Monday-Friday 9:00 AM – 12:00 Noon

Grades 1 - 3

☐ How to Build Your Own Robot Fee: $209

☐ Build Your Own Dollhouse Fee: $209

June 22, 2015-June 26, 2015	Monday-Friday	9:00 AM – 12:00 Noon

Grades 1 - 3

☐ Astronaut and Space — Fee: $299

☐ Pirate Science Camp — Fee: $179

July 6, 2015-July 10, 2015	Monday-Friday	9:00 AM – 12:00 Noon

Grades 1 - 3

☐ LEGO® II — Fee: $209

July 13, 2015-July 17, 2015	Monday-Friday	9:00 AM – 12:00 Noon

Grades 1 - 3

☐ Gardening Camp — Fee: $159

July 20, 2015-July 24, 2015	Monday-Friday	9:00 AM – 12:00 Noon

Grades 1 - 3

☐ LEGO ® Flight Camp: Build Your Own Plane — Fee: $229

July 27, 2015-July 31, 2015	Monday-Friday	9:00 AM – 12:00 Noon

Grades 1 - 3

☐ Doc Maverick — Fee: $229

August 3, 2015-August 7, 2015	Monday-Friday	9:00 AM – 12:00 Noon

Grades 1 - 3

☐ All Aboard the LEGO® Math Train — Fee: $209

☐ Engineering Adventures — Fee: $229

UNIVERSITY OF TEXAS

Health Services

Consent for Treatment of a Minor Who Does Not Have Legal Power to Consent

Box 19329 605 S. West St. Arlington, TX 76019 T.817.272.2771 F.817.272.3829 www.uta.edu/healthservices

Patient Name: _____

UT Arlington I.D. #: _____

D.O.B.: _____ Gender: _____

Provider: _____ Date: _____

Name of Minor: _____

Date of Birth: _____

Address (Street, City, State, Zip Code):

_____

Parent/Guardian Phone Number: _____ HOME _____ WORK

I, the undersigned as the parent or legal guardian of _____ (a minor) hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending physician, appropriate staff, and The University of Texas at Arlington and its officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical, and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

_____ SIGNATURE OR PARENT/LEGAL GUARDIAN

_____ DATE

_____ PRINT NAME

Medical Information Related to Minor:

Allergies: _____

Current Medications: _____

Date of Last Tetanus Booster: _____

Pertinent Medical History: _____

☐ CONDITION WAS URGENT.

Parental/guardian consent for treatment was obtained by telephone from:

_____ NAME OF PARENT/LEGAL GUARDIAN

_____ TIME AND DATE

By _____

UT Arlington Health Services complies with all applicable Texas medical privacy statutes including Occupations Code Chapter 159 and Health & Safety Code Chapter 611 related to information obtained as a result of patient treatment. Health Services will safeguard the privacy and confidentiality of all such information.

Box 19329 605 S. West St. Arlington, TX 76019 T.817.272.2771 F.817.272.3829 www.uta.edu/healthservices

Texas State Privacy Law (HB 300)

Effective Date: 04/14/2003
Revised Date: 03/20/2012

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. **Purpose:** The University of Texas at Arlington Health Services (UTAHS), its professional staff and employees follow the privacy practices described in this Notice. UTAHS is required by State Law to maintain the privacy of your health information, and to protect the integrity, confidentiality, and availability of your health information when it is collected, maintained, used or transmitted by Health Services. However, UTAHS must use and disclose your medical information to the extent necessary to provide you with quality health care. To do this, UTAHS must share your medical information as necessary for treatment, payment, and health care operations.

2. **What Are Treatment, Payment, and Health Care Operations?** Treatment includes sharing information among health care providers involved in your care. For example, your provider may share information about your condition with the pharmacist to discuss appropriate medications or with radiologists or other consultants in order to make a diagnosis. Health Services may use your medical information as required to obtain payment for your treatment. We also may use and disclose your medical information to improve the quality of care, for example, for review and training purposes.

3. **How Will UTAHS Use My Medical Information?** Your medical information may be used or disclosed, unless you ask for restrictions on a specific use or disclosure, for the following purposes:

    - Family members or close friends who may consent to your treatment or who are involved in the payment for your treatment.
    - American Red Cross (or a government disaster relief agency) if you are involved in a disaster relief effort.
    - Appointment reminders.
    - To inform you of treatment alternatives or benefits or services related to your health that may be of interest to you. (You will have an opportunity to refuse to receive this information.)
    - As required by law.
    - Public health activities, including disease prevention, injury or disability; reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence (if you agree or as required or authorized by law).
    - Health oversight activities, e.g., audits, inspections, investigations, and licensure.
    - Lawsuits and disputes.
    - Law enforcement (e.g., in response to a court order or subpoena).
    - Certain research projects approved by an Institutional Review Board.
    - To prevent a serious threat to health or safety.
    - National security and intelligence activities.
    - Workers' Compensation. (Your medical information regarding benefits for work-related illnesses may be released as appropriate.)
    - To carry out treatment, payment, and health care operations functions through business associates (e.g., to install a new computer system).
    - Alcohol and drug abuse information has special privacy protections. UTAHS will not disclose any information identifying an individual as being a patient or provide any medical information relating to the patient's substance abuse treatment unless: (i) the patient consents in writing; (ii) a court order requires disclosure of the information (iii) medical personnel need the information to meet a medical emergency; (iv) qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits, or program evaluation; or (v) it is necessary to report a crime or a threat to commit a crime, or to report abuse or neglect as required by law.

4. **Your Authorization Is Required for Other Disclosures.** Except as described above, we will not use or disclose your medical information unless you authorize (permit) UTAHS, in writing, to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation.

5. **You Have Rights Regarding Your Medical Information.** You have the following rights regarding your medical information, provided that you make a written request to invoke the right on the form provided by UTAHS:

   - **Right to request restriction.** You may request limitations on your medical information we use or disclose for health care treatment, payment, or operations (e.g., you may ask us not to disclose that you have had a particular procedure), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
   - **Right to confidential communications.** You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.
   - **Right to inspect and copy.** You have the right to inspect and copy your medical information regarding decisions about your care; however psychotherapy notes may not be inspected or copied. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied; in some cases you may request review of the denial by another licensed health care professional chosen by UTAHS. Health Services will comply with the outcome of the review.
   - **Right to request amendment.** If you believe that the medical information we have about you is incorrect or incomplete, you may request an amendment on the form provided by UTAHS, which requires certain specific information. Health Services is not required to accept the amendment.
   - **Right to accounting of disclosures.** You may request a list of the disclosures of your medical information that have been made to persons or entities in the past ten years (such list will not include disclosures made pursuant to an authorization or for treatment, payment, and health care operations). After the first request, there may be a charge.
   - **Right to a copy of this Notice.** You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this Notice at our web site, http://www.uta.edu/healthservices.

6. **Notice of Security Breach.** UTAHS is required to notify you if your protected health information has been breached. The notification will occur by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure that compromises the privacy or security of protected health information. The notification requirements under this section only apply if the breach poses a significant risk for financial, reputational, or other harm to you. The notice will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches. Not every impermissible use or disclosure of protected health information constitutes a reportable breach. The determination of whether an impermissible breach is reportable hinges on whether there is a significant risk of harm to you as a result of impermissible activity. For example, if your protected health information was inappropriately shared with a billing clerk and she understood her confidentiality obligations, you would not need to be notified of the breach. If we inadvertently disclosed that you received services at UTAHS, without more specifics, this also may not be a reportable breach because it may not have been a significant risk of financial or reputational harm. The key to determining potential harm is whether sufficient information was released to allow identity theft or harm you because of the likelihood of sharing sensitive health data.

7. **Requirements Regarding This Notice.** UTAHS is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. UTAHS may change this Notice and these changes will be effective for medical information we have about you as well as any information we receive in the future. Each time you register at UTAHS for health care services, you may receive a copy of the Notice in effect at the time.

8. **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the University of Texas at Arlington, Director of Health Services, 605 S. West Street, Box 19329, Arlington, TX 76019, 817-272-0679. To obtain further information about the federal privacy rules or to submit a complaint to the Texas Department of State Health Services, you may contact the Department by telephone at 214-767-4056, fax at 512-458-7111 or by electronic mail at www.dshs.tx.us, or by postal mail addressed to:

Texas. Department of State Health Services
1100 W. 49th Street
Austin, TX 78756

You will not be penalized or retaliated against in any way for making a complaint to UTAHS or the Texas Department of State Health Services.

Contact the University of Texas Arlington's Director of Health Services at 817-272-0679 if:
- **You have a complaint;**
- **You have any questions about this Notice;**
- **You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or**
- **You wish to obtain a form to exercise your individual rights described in paragraph 8.**

UNIVERSITY OF TEXAS ARLINGTON

Health Services

Form 9-5
03/20/2012

Notice of Privacy Practices
Acknowledgement Receipt Form

Box 19329 605 S. West St. Arlington, TX 76019 T.817.272.2771 F.817.272.3829 www.uta.edu/healthservices

Your signature below indicates that you have been offered a copy of the University of Texas Arlington Health Services (UTAHS) Notice of Privacy Practices. If you have any questions about the Notice of Privacy Practices, please call UT Arlington's Director of Health Services at 817-272-0679.

I have been offered the Notice of Privacy Practices.

Patient / Visitor Signature	Date
Print Patient / Visitor Name	Date of Birth
ID#	Gender
Parent / Guardian Signature (if patient is under 18)	Date

FOR OFFICE USE ONLY

UTAHS will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If the patient is unwilling and / or unable to sign this acknowledgement, UTAHS must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Reason: _____

Staff Signature: _____

You may be entitled to know what information UT Arlington collects concerning you. You may review and have UT Arlington correct this information according to procedures set forth in UT System Administration UTS139. The law is found in sections 552.021, 552.023 and 559.004 of the Texas Government Code.

UNIVERSITY OF TEXAS ARLINGTON

The University of Texas at Arlington
Release and Indemnification Agreement for Minors

Form 15-13
Rev. 04/01/2010

PARTICIPANT: (Name and Address)

_____

_____

_____

DESCRIPTION OF ACTIVITY OR TRIP: _____

_____

_____

LOCATION: _____ **DATE(s):** _____

I am the Parent/Guardian of the above-named Participant who is under eighteen years of age and am fully competent to sign this Agreement.

I give permission for Participant to participate in the above-referenced Activity or Trip. I acknowledge that the nature of the Activity or Trip may expose Participant to hazards or risks that may result in Participant's illness, personal injury or death and I understand and appreciate the nature of such hazards and risks.

In consideration of Participant being permitted to participate in the Activity or Trip, I hereby accept all risk to Participant's health and of his/her injury or death that may result from such participation and I hereby release the above named Institution, its governing board, officers, employees and representatives from any and all liability to Participant, Participant's personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to Participant's property and for any and all illness or injury to Participant's person, including his/her death, that may result from or occur during Participant's participation in the Activity or Trip, whether caused by negligence of the Institution, its governing board, officers, employees, or representatives, or otherwise. I further agree to indemnify and hold harmless the Institution and its governing board, officers, employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from Participant's negligent or intentional act or omission while participating in the described Activity or Trip.

I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE A RELEASE OF ALL CLAIMS AND CAUSES OF ACTION FOR PARTICIPANT'S INJURY OR DEATH OR DAMAGE TO PARTICIPANT'S PROPERTY THAT OCCURS WHILE PARTICIPATING IN THE DESCRIBED ACTIVITY OR TRIP AND IT OBLIGATES ME TO INDEMNIFY THE PARTIES NAMED FOR ANY LIABILITY FOR INJURY OR DEATH OF ANY PERSON AND DAMAGE TO PROPERTY CAUSED BY PARTICIPANT'S NEGLIGENT OR INTENTIONAL ACT OR OMISSION.

_____
Signature of Parent/Guardian

_____
Address (if different than Participant's)

_____
Date Signed

_____
Signature of Witness

_____
Date Signed

You may be entitled to know what information UT Arlington collects concerning you. You may review and have UT Arlington correct this information according to procedures set forth in UT System Administration UTS139. The law is found in sections 552.021, 552.023, and 559.004 of the Texas Government Code.

UNIVERSITY OF TEXAS ARLINGTON

The University of Texas at Arlington

Photographic Consent and Release

I hereby authorize The University of Texas at Arlington , and those acting pursuant to its authority to:

(a) Record my likeness and voice on a video, audio, photographic, digital, electronic or any other medium.

(b) Use my name in connection with these recordings.

(c) Use, reproduce, exhibit or distribute in any medium (e.g. print publications, video tapes, CD-ROM, Internet/ WWW) these recordings for any purpose that the University, and those acting pursuant to its authority, deem appropriate, including promotional or advertising efforts.

I release the University and those acting pursuant to its authority from liability for any violation of any personal or proprietary right I may have in connection with such use. I understand that all such recordings, in whatever medium, shall remain the property of the University. I have read and fully understand the terms of this release.

Name: _____

Address: _____
Street

_____ _____ _____
City State Zip

Phone: _____

Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____

You may be entitled to know what information UT Arlington collects concerning you. You may review and have UT Arlington correct this information according to procedures set forth in UT System Administration UTS139. The law is found in sections 552.021, 552.023 and 559.004 of the Texas Government Code.

CONTINUING EDUCATION
The University of Texas ARLINGTON

Kids and Teens University Authorized to Pick-Up Form

Authorized Person(s) Pick-up Form

I, _____ , parent / guardian

of _____ , hereby authorize

the following person(s) to pick-up my child in the event that I am not able to do so.

*All persons on the authorized pick-up list **must** show a drivers license daily or they will not be allowed to pick up your child.*

Please fill in the full name of the person(s) and the relationship to your child and contact number:

Please include the parent/guardian's name on this list

Name:	Relationship:	Contact Number:
1.		
2.		
3.		
4.		
5.		
6.		

University of Texas Arlington Kids and Teens University Forms Checklist

In order for your child to participate in the Kids and Teens University Program the following forms must be completed and submitted to UT Arlington Continuing Education Department.

- ☐ Kids and Teens University Registration Form
  Complete and Return - Required
- ☐ Consent for Treatment of a Minor Form
  Complete and Return - Required
- ☐ Notice of Privacy Practices
  Keep for Your Records
- ☐ Notice of Privacy Practices Acknowledgement of Receipt
  Complete and Return – Required
- ☐ Release and Indemnification Agreement for Minors
  Complete and Return - Required
- ☐ Photographic Consent & Release
  Complete and Return - Optional
- ☐ Authorized Person(s) Pick-up
  Complete and Return - Required

If you have any questions please call 817-272-2581.