HOW TO APPLY

Submit completed application to:

EMAIL: lreal@fau.edu
FAX: 561-409-9031
MAIL/IN-PERSON:
777 GLADES ROAD (SE 308)
ATTN: SUMMER SCIENCE INSTITUTE
FLORIDA ATLANTIC UNIVERSITY
BOCA RATON, FL 33431

APPLICATION CHECKLIST

✓ Completed Application
✓ Signed Waiver and Release
✓ $50 non-refundable application fee paid online via credit card at
  https://epay.fau.edu/C20081_ustores/web/store_cat.jsp?STOREID=18
  &CATID=69 or check (made payable to Florida Atlantic University)
SUMMER SCIENCE INSTITUTE
Fostering American Innovation
A S.T.E.M. INITIATIVE
2016 APPLICATION

Student Name_________________________ Gender: __________
Ethnicity: ______________________________
Address ____________________________________
City __________________ Zip code __________
Home phone ___________ Cell phone ____________
Email _____________________________________
Date of Birth: ___________________________
Student's current age __________
Student's grade in school as of August 2016 __________
Student's school as of August 2016 __________________________

Parent/Guardian name______________________________________
Relationship to student: _________________________________
Address ______________________________________________
City __________________ Zip code __________
Home phone ___________ Work phone ________________
Cell phone __________________________
Email _____________________________________
Parent/Guardian name ____________________________________________
Relationship to student: __________________________________________
Address _________________________________________________________
City ___________________________ Zip code _________________________
Home phone ________________ Work phone __________________________
Cell phone ____________________
Email __________________________

How did you hear about us? _______________________________________

OFFICE USE:

APP FEE PAID: DATE: 
DEP PAID: DATE: 
BAL PAID: DATE: 

COMMENTS:
**CHOOSE YOUR SESSION**

**AGES 11-13 (Middle School)**
- June 13-July 8 (9:00 am – 2:00 pm, M-F)
- July 11-August 5 (9:00 am – 2:00 pm, M-F)

**AGES 14-17 (High School)**
- June 13-July 8 (9:00 am – 2:00 pm, M-F)
- July 11-August 5 (9:00 am – 2:00 pm, M-F)

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**T-SHIRT**

Adult XL _______ Adult L _______ Adult M _______ Adult S _______

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**ESSAY**

Please attach a separate sheet with an essay, at least 250 words, stating:

1. What areas of science interest you the most and why?
2. What are you hoping to accomplish if admitted into the FAU Summer Science Institute?

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**PHOTO PERMISSION**

Photographs will be taken during the INSTITUTE for possible publicity purposes. Please indicate your permission for your child to be photographed.

**Signature** ____________________________________________________________
All students may ONLY be picked up by the person(s) authorized by the registering parent/guardian. Drop off starts at 8:45 AM in the Biomedical Building south drop off loop (near the administration building). Pick up is at 2:00 PM in the same place. Please be on time when dropping off and picking up your child. A fee will be assessed for late pick-up.

**Adults to whom student will be released (PRINT):**
Name__________________________ Phone ____________________
Relationship to student: ________________________________

Name__________________________ Phone ____________________
Relationship to student: ________________________________

Name__________________________ Phone ____________________
Relationship to student: ________________________________

**State Issued ID required for pick-up**

Please sign below if your child will be driving himself/herself to and from FAU. A parking permit is required from FAU Traffic and Parking. Please visit [http://www.fau.edu/parking/](http://www.fau.edu/parking/) and [http://www.fau.edu/parking/temporary_permit.php](http://www.fau.edu/parking/temporary_permit.php) for details.

__________________________  __________________________
**Parent/Guardian Signature**  Date

Please sign below if you give permission for your child to sign in and out on their own without parent/guardian (only for students ages 14 and up).

__________________________  __________________________
**Parent/Guardian Signature**  Date
Student’s Name _______________________________________________

Parent/Guardian Name __________________________________________

Medications student is taking: (Institute staff will not administer medication)
________________________________________________________________________

Reason for medication: ______________________________________________________________________________________

Allergies _________________________________________________________________________________________________

Physical Limitations ______________________________________________________________________________________

Physician Name and Number: ______________________________________________________________________________

Health Insurance Name __________________________________________

ID Number: ___________________________ Group Number: _____________________________

Other relevant medical conditions _____________________________________________________________
______________________________________________________________________________________________

Please provide a copy of the student’s health insurance.

If your child needs medication administered to them please fill out the following pages. All medication will be kept in a locked drawer where the student will have access to it when needed.
Authorization to Administer Medication in Program

Student Name:__________________________DOB:___________________ Grade:_________

Last Name, First Name

Part I
Dear Parent or Healthcare Provider,
When considered medically necessary, students may receive medications and treatments as ordered by a licensed healthcare provider, during the program day. Please complete the following information. Be advised that:
Orders are valid for one program year.
• NO MEDICATION OR TREATMENT may be given by the program nurse or designee until this form is completed and properly labeled medication is received. THIS INCLUDES OVER THE COUNTER MEDICATIONS SUCH AS TYLENOL, MOTRIN, AND COUGH DROPS.
• A physician signature and a parent signature must be on this form.
• All medications must be stored in their original containers with an appropriate pharmacy label on each bottle. All labels will include the student’s name, does, frequency, route, time of administration of the medication.

Part II
Dear Healthcare Provider,
The parent initiates this request and has the responsibility for supplying medication and/or treatment supplies. Should the student display any adverse reactions, the parent will be contacted immediately, emergency care will be provided as needed and the medication/treatment discontinued. The parent will be responsible for contacting you for follow-up care as you deem necessary. Please sign below, acknowledging that you understand the procedure for management of side effects to prescribed medications or treatments. Thank you for your assistance.

Part III
Medication Treatment #1:
Name of Drug/Treatment___________________________________________________
Dosage_________ Route_________ Frequency__________ (include times and duration)
Medication form:
__ pill/capsule __ inhaler __ ear drops __ eye drops __ liquid __ injectable
Known adverse reactions/side effects__________________________________________
Prescribed treatment for side effects, if other than as outlined above
_______________________________________________________________________

Medication Treatment #2:
Name of Drug/Treatment___________________________________________________
Dosage_________ Route_________ Frequency__________ (include times and duration)
Medication form:
__ pill/capsule __ inhaler __ ear drops __ eye drops __ liquid __ injectable
Known adverse reactions/side effects__________________________________________
Prescribed treatment for side effects, if other than as outlined above
_______________________________________________________________________
Medication Treatment #3:
Name of Drug/Treatment___________________________________________________
Dosage________ Route________ Frequency________ (include times and duration)
Medication form: __ pill/capsule __ inhaler __ ear drops __ eye drops __ liquid __ injectable
Known adverse reactions/side effects__________________________________________
Prescribed treatment for side effects, if other than as outlined above

Part IV
Parent Permission:
I hereby give permission for my child to receive the above medications/treatments during program hours. I understand that medications may be administered by the program registered nurse or designee. This designee may be a nonmedical person. If a treatment requires a medical or nursing assessment prior to administration, and a licensed medical person is not available, the medication and/or treatment will not be given. This medication and/or treatment is considered a medical necessity and ordered by a licensed healthcare provider. I hereby release the FAUS District, its agents and employees from any and all liability that may result from my child receiving this medication and/or treatment.

Parent/Guardian Signature __ Date __ Healthcare Provider Signature __ Date __

Parent/Guardian Name (Print) ___________________________ Phone # __________

Healthcare Provider Name (Print) ___________________________ Phone # __________

Do Not Write Below This Line-Program Use Only
Comments:
________________________________________________________
________________________________________________________

Medication/Treatment Received
Date: ___________ Amount: ___________
Approved by: ___________ (Program Nurse Signature)
Logged in Medical Administration Book: __ Yes __ No
Secured in locked cabinet: __ Yes __ No

Date: ___________ Amount: ___________
Approved by: ___________ (Program Nurse Signature)
Logged in Medical Administration Book: __ Yes __ No
Secured in locked cabinet: __ Yes __ No

Date: ___________ Amount: ___________
Approved by: ___________________(Program Nurse Signature)
Logged in Medical Administration Book: __ Yes __ No
Secured in locked cabinet: __ Yes __ No

Date: ____________ Amount: ________________
Approved by: ___________________(Program Nurse Signature)
Logged in Medical Administration Book: __ Yes __ No
Secured in locked cabinet: __ Yes __ No

Date: ____________ Amount: ________________
Approved by: ___________________(Program Nurse Signature)
Logged in Medical Administration Book: __ Yes __ No
Secured in locked cabinet: __ Yes __ No

Date: ____________ Amount: ________________
Approved by: ___________________(Program Nurse Signature)
Logged in Medical Administration Book: __ Yes __ No
Secured in locked cabinet: __ Yes __ No
EMERGENCY CONTACT INFORMATION

Name: ____________________________________________________________
Relationship to participant: _________________________________________
Address, City, State, Zip: __________________________________________
Emergency phone#: ______________________________________________

Name: ____________________________________________________________
Relationship to participant: _________________________________________
Address, City, State, Zip: __________________________________________
Emergency phone#: ______________________________________________
I do hereby release, acquit, hold harmless, and forever discharge the state of Florida, the Florida Board of Governors, the Florida Atlantic University Board of Trustees, and their respective officers, directors, employees, representatives, agents and volunteers of and from all actions, liability and responsibility, whatsoever, however caused, for any and all loss, illness, personal injury, death or property damage sustained by my child as a consequence of his/her participation in the Florida Atlantic University Summer Science Institute.

The undersigned parent(s) or legal guardian(s) of the above named child hereby consents and grants permission to Florida Atlantic University, and its Summer Science Institute, in case of injury or illness, to administer first aid or to have a health professional provide medical assistance and/or treatment for the above-named child. I understand that in case of an emergency, 911 will be called. I authorize Emergency Medical Services (EMS) to administer any medical treatment, medication, or appliance deemed necessary by EMS. I also authorize transportation by EMS to the nearest appropriate medical facility, if determined necessary. I understand that I will be responsible for payment of all EMS, hospital, and physician charges for emergency services to the above-named child.

I ________________________________ have read and understand the foregoing document and do freely accept its terms.

Parent/Guardian Signature ________________________________ Date __________
Tuition

- $875 for a 4 week session **June 13 – July 8, 2016** or **July 11 – August 5, 2016** from 9:00am to 2:00pm, M-F.
- Enrollment in this program is highly competitive and we recommend applying early. An application must be submitted with the non-refundable $50 application fee. Email notification of acceptance will be sent and a deposit must be submitted within two (2) weeks.
- All fees, in full, are due by May 16, 2016.

Refund Policy

- There is a $50 non-refundable application fee.
- Upon acceptance, there is a $400 non-refundable deposit that applies towards tuition.
- Any registration cancellations must be made a minimum of four (4) weeks prior to the first day of any registered session.
- If your child is asked to leave the Institute for disciplinary reasons, you will not receive a refund or credit.
- If full payment is not received by May 16, 2016, your registration will be cancelled.

Attire

Students should wear comfortable clothing and shoes. The T-shirts provided must be worn daily. Additional T-shirts may be purchased for $10 through the Continuing Education Office.

Lunch

Lunch is provided daily for all students at the University Cafeteria.
**What to Bring**
- Snacks and water
- Sunscreen
- Umbrella
- Backpack
- Notebook
- Pens/pencils
- Calculator

**Activities**
During the four weeks of the Summer Science Institute, your child will be learning about marine science, environmental science, geology, physics, genetics, molecular biology and biotechnology, astronomy and more! Students will have the opportunity to participate in hands on experiments and activities.

**Supervision**
The Summer Science Institute maintains a student-to-instructor ratio of 12 or better at all times. All staff are fingerprinted and receives risk management training and must pass a criminal background check prior the start of the Summer Science Institute.

**Contact Information**
For more information or to contact the institute coordinator during operating hours please call: 561-409-9031 or email lreal@fau.edu

Please make sure you notify us if your child will not be coming one day for any reason or if you are running late or have another issue with getting your child here on time.

**Student Code of Conduct**
For the official FAU student code of conduct, please go online to: