

## 2018 UC San Diego Overnight Parent/Guardian Release Form

Scan and upload this form to your Overnight Application
Alternatively, you may e-mail or fax this form to the corresponding office by 11:59pm on Wednesday, March 28, 2018:

BSU Overnight Program: Fax: 858-822-0300 | E-mail: <a href="mailto:brc@ucsd.edu">brc@ucsd.edu</a>
IDEA Overnight Program: Fax: 858-822-5870 | E-mail: <a href="mailto:idea@ucsd.edu">idea@ucsd.edu</a>
SIAPS Overnight Program: Fax: 858-822-5005 | E-mail: <a href="mailto:overnightspacesucsd@gmail.com">overnightspacesucsd@gmail.com</a>

Stu	udent's Last Name	First Name	Middle Initial	Date of Birth	
1.	,,,, = ,, = ,, = ,, = ,, = ,, = ,, = ,				
	If yes, please describe:				
2.	Any special dietary needs (i.e. food allergies, religious observance, vegetarian, etc.)?				
	If yes, please describe:				
3.	Any medication allergies (i.e., penicillin, aspirin, etc.) or other allergies (latex, insect stings)?				
		If yes, please specify:			
4.	-	s the student being treated for any medical condition (i.e., asthma, diabetes, epilepsy, etc.)?  yes no			
	If yes, please specify:				
5.	Is the student covered by medical insurance?				
	If yes, please specify of	ompany:	Group	o #:	
In	case of emergency,	please contact:			
			Dalatia nahin ta	Obstant	
Na	me		Relationship to	Student	
Str	eet Address		City/State/Zip		
(	)	()	·		
Da	ytime Phone	Evening Phone	Alternate Phone		
Pa	erent/Guardian Certif	ication and Signature (Plea	ase initial each line	to indicate your agreement)	
		participate in the UC San Diego Ov		,	
	-		-	n requires a reasonable level of participation	
		ected that my student follow all pol			
		dence hall to which my student will ego to which the student has been		ernight Program may not be associated with the	
		ernight Program is limited to the UC n Diego staff member or Overnight		d I agree that my student must remain on of the program.	
				he campus, I will not hold UC San Diego ergency contact listed above will be	
	program, nor will they brid	ng alcohol and/or drugs with them t	to the program. In the e	t not consume alcohol or drugs during the vent that it is made aware that my student ontacted immediately and will be dismissed from	
	provide first aid to my stu If I have insufficient or no	dent. If my student needs medical	attention, my health ins	aff members to take necessary steps to urance carrier will be used if necessary. lical expenses. In case of emergency,	
Pa	rent / Guardian Full Name	(please print) Parent/Gu	uardian Signature	Date	
Stu	udent Signature				