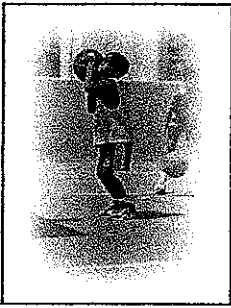


ALBANY STATE UNIVERSITY & THE CITY OF ALBANY



Since 1968, the National Youth Sports Program (NYSP) has combined sports instruction with exciting educational programs for youths ages 10-16. Enrollment is open to all youngsters in the community whose parent(s) or guardian(s) meet(s) Department of Health and Human Services income guidelines at no cost.

NYSP participants also receive – (1) a NYSP T-shirt, (2) a daily USDA-approved meal, (3) transportation to campus (if necessary), (4) a medical examination, (5) accident-medical insurance coverage and (6) interaction with college students and staff.

Youths practice standard sports and learn new ones!



*Activities include swimming and a variety of other sports which may include basketball, football (touch or flag), softball, tennis, track and field, soccer, volleyball, dance/aerobics, badminton, gymnastics and wrestling.

*Top-quality sports equipment is provided by the program.

Community leaders bring information to participants on:

- *Alcohol-and other drug-abuse prevention
- *Nutrition and personal health
- *Career opportunities and job responsibilities
- *Higher education and community concerns
- *Math/sciences instruction (at selected sites)



NYSP Participant Application

Name: _____ Telephone: _____
Last First MI

Address: _____ M _____ F _____ Age _____
City State Zip Code Birthdate: ____/____/____

Social Security Number: _____ - _____ - _____ NYSP Returnee: Yes _____ No _____ Number of Years in NYSP _____

Ethnicity: (check all that apply) _____ American Indian/Alaska Native _____ Asian _____ Native Hawaiian/Pacific Islander
 _____ Black Non-Hispanic _____ Hispanic _____ White Non-Hispanic

Parent or Legal Guardian: _____

Telephone: Home _____ Work _____

Emergency Contact: Name _____

Relationship: _____ Telephone: Home _____ Work _____

Address: _____

I understand and consent that a medical examination will be required before enrollment in NYSP and that the host institution and/or NYSP is authorized to obtain medical care or treatment deemed necessary.

Parent/Guardian Signature _____ Date _____

Office Use Only	
Residing within target area:	Yes _____ No _____
Eligible:	Noneligible _____
Medical examination record:	Yes _____ No _____

**AUTHORIZATION, RELEASE AND WAIVER OF LIABILITY
FOR ALBANY STATE UNIVERSITY NYSP PROGRAM**

I, _____, the parent or legal guardian of _____, a minor enrolled as a participant in the Albany State University National Youth Sports Program (ASU-NYSP), do hereby enter into this Authorization, Release and Waiver of Liability on behalf of myself and the above named child, our heirs and assigns. I acknowledge that this is a voluntary activity for which I freely give permission for my child's participation. I understand that the instructional, recreational and physical activities conducted by ASU-NYSP involve certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries and/or property damage or loss. In consideration for the above-named child's participation in the programs and activities coordinated by ASU-NYSP, I hereby freely, voluntarily and knowingly assume all risks on behalf of my child as his/her parent or legal guardian.

I consent to the rules and regulations imposed by the ASU-NYSP staff on program participants and I agree to reinforce said rules by discussing them with my child and encouraging his/her compliance. I grant permission to ASU-NYSP to transport and/or arrange for transportation for the above-named child if such is needed to participate in any of the programs and activities of ASU-NYSP. I understand that travel of any kind, whether by vehicle, foot or any other means, also involves inherent risks that I voluntarily assume on behalf of my child. In case of a medical emergency, I hereby grant consent to the staff of ASU-NYSP to provide immediate medical attention and/or seek the services of professional medical personnel, the expenses for which I assume full responsibility.

I further grant permission and consent to ASU-NYSP to photograph or otherwise electronically or digitally record my image or the image of my child while involved in any of the activities sponsored by ASU-NYSP. Said images may be published in print or electronic form and disseminated to the general public in newsletters, posters, displays, films, videos, or websites of ASU-NYSP for publicity, informational and educational purposes. Additionally, I willingly give my consent to ASU-NYSP to enter program data about my child and me into their computer information system.

In consideration of the participation of the above-named child in the programs and activities of the ASU-NYSP, I hereby indemnify, release, hold harmless and discharge the Board of Regents of the University System of Georgia (hereafter BOR), Albany State University (hereafter ASU), and/or the ASU-NYSP, their officers, trustees, agents and employees from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or relating to any loss, damage or injury, including death, that may be sustained by the above-named child, or damage to any property belonging to said child, whether caused by the negligence of the BOR, ASU and/or ASU-NYSP, or otherwise.

I have read and fully understand the contents of this entire document, and consent to the provisions contained herein.

IN WITNESS WHEREOF, I set my hand hereto as of the date set forth below:

_____ Signature of Parent/Legal Guardian	_____ Date	_____ Print—Name of Student
_____ Witness	_____ Date	

NASA SEMAA 2009



Summer Student Application

Science, Engineering, Mathematics and Aerospace Academy

STUDENT INFORMATION

Last Name: _____ First Name: _____ MI _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Date of Birth: ____/____/____ Gender Male Female

School Name: _____ Grade Level 2008-2009: _____

Has the student applicant participated in SEMAA before? Yes No

If yes, please check all applicable grades

K 1 2 3 4 5 6 7 8 9 10 11 12

What session did you participate in NASA SEMAA (Please Check and Date one):

Fall _____ Year _____ Winter _____ Year _____ Spring _____ Year _____

School: _____ Grade level in 2008-2009 school year: _____

Please select one session:

(I) June 1-5 (II) June 8-12 (III) June 15-19 (IV) June 22-26

Select one:

9:00-12:00 9:00-12:00 9:00-12:00 9:00-12:00
 1:00-4:00 1:00-4:00

ADDITIONAL INFORMATION

In order to determine the degree to which members of each ethnic/racial group are reached by this program, NASA requests that the student applicant check the appropriate block(s) below. Submission of this information is VOLUNTARY and will not be used when considering this application.

ETHNICITY (Check One)

- American Indian/Alaskan Native Asian Black/African American
- Hispanic/Latino(a) Native Hawaiian/Pacific Islander White (Non-Hispanic)
- Two or More Races Other (Please specify) _____

Does the student applicant qualify for free or reduced lunch? Yes No

SPECIAL NEEDS

SEMAA defines children with disabilities as those children who have been diagnosed with a physical or mental

(CONTINUED ON PAGE 2)

impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment.

Does the student applicant have a diagnosed physical or mental impairment? Yes No

If yes, please explain and describe any special accommodations that will be required in the classroom or lab.

Does the student applicant have any special dietary needs or restrictions? Yes No

If yes, please list all special dietary needs or restrictions.

PARENT AND GUARDIAN INFORMATION

I do hereby release and discharge NASA, the National SEMAA Office, this SEMAA site, members, administrators, partners and agents from any and all claims, present and future, known and unknown, due to or arising from any manner from my child's participation in the project or related activities sponsored by SEMAA. I have read or someone from the SEMAA project has read and explained the information contained in this form to me. I willing agree, and give my consent to let SEMAA enter data about my child and me into their computer information system. I also give permission for my child to be photographed participating in activities and allow SEMAA to release any and all pictures for related publicity purposes only. I also give my child permission to attend any field trips that are incorporated into the summer program. In case of an emergency, consent is granted to the staff of SEMAA to provide medical services through the appropriate medical facilities and/or services.

Parent/Guardian Signature: _____ Print Name: _____

Daytime Phone: () _____ Best time to call: _____

EMERGENCY CONTACT INFORMATION

In case of an emergency, and you cannot reach me at the daytime or home telephone numbers provided, please contact...

Emergency contact name: _____

Contact person's relationship to student: _____

Daytime Phone: () _____ Home Phone: () _____

PARTICIPATION IN OTHER NASA EDUCATIONAL PROJECTS & ACTIVITIES

In addition to SEMAA, has the student applicant participated in any other NASA sponsored projects and/or activities? Yes No

If yes, please check all NASA sponsored programs, projects and/or activities that the applicant has participated in.

- Amateur Radio on the International Space Station (ISS)
- Contest/competitions (i.e., FIRST Robotics, Great Moonbuggy Race, Exploring Space Challenge, etc...)
- Distance learning activities through the Digital Learning Network (DLN)

~~PLEASE MAIL OR FAX THIS COMPLETED APPLICATION TO YOUR NEAREST SEMAA PROJECT OFFICE (for a complete list of SEMAA Project Sites nation-wide, visit our website at www.semaa.net)~~

**ALBANY STATE UNIVERSITY
NATIONAL YOUTH SPORTS PROGRAM HEALTH SCREENING**

Name of Child's School _____ Year _____

Parent & Child: Complete this form before you see the Doctor

Name: _____ Age: _____

Race: _____ Sex: _____ County: _____

Does your child have a doctor? No _____ Yes _____

Clinic/Doctor's name _____

When was the last time your child was seen by a doctor or by a clinic/health department?

Date: _____ Why: _____

Present Health History:

Does your child have any health problems? No _____ Yes _____

Please list _____

Does your child have any allergies?

Drug allergies: No _____ Yes _____ Please List _____

Food allergies: No _____ Yes _____ Please List _____

Other allergies: No _____ Yes _____ Please List _____

Is your child taking any medications? No _____ Yes _____

Please list all medications your child is taking: _____

Are your child's immunizations current? No _____ Yes _____

Has your child had the following: ___ Chicken pox ___ Chicken pox vaccine ___ Hepatitis Series

Past Health Status:

Has your child had any serious illnesses? (Check all the apply)

___ Chronic lung problems ___ Heart problems ___ Rheumatic fever ___ Asthma ___ Diabetes

___ Kidney problems ___ Seizures ___ Hypertension (high blood pressure)

Was your child born early? No _____ Yes _____

Was your child sick at birth? No _____ Yes _____

Has your child been diagnosed as a Special Needs Child? No _____ Yes _____

Has your child had any serious injuries? (Check all that apply)

___ Head injury ___ Fracture ___ Dislocations ___ Burns ___ Other (please list) _____

Has your child had an operation? No _____ Yes _____

When? _____ Why? _____

Family Medical History:

Does anyone in your child's family have any of the following? (Check if parents, grandparents, sisters, brothers, aunts or uncles have any of the following)

- Cancer(who) _____
- Hypertension(high blood pressure) Diabetes(high blood sugar) Sickle cell anemia
- Heart problems Anemia Seizures Stroke Suicide Arthritis
- Other (please list) _____

Review of Systems: Does your child have any of the following? (Check all that apply)

- Skin rash or sores Headaches Dizziness Vision problems Wear glasses Eye Pain
- Hearing problems Ear aches Toothaches Sore throat Breathing problems
- Chest pain Trouble breathing when exercising Heart Murmur Stomach problems
- Pain when going to the bathroom Leg problems Back problems Abdominal Pain
- Sores on or discharge from vagina or penis Problems with walking or running
- Behavioral problems

Social History:

Has your doctor ever told you that you could not participate in sports or sports related activities?

No Yes

Do you exercise every week? No Yes

How often? everyday 1-2 times a week 2-4 times a week

Do you have any problems with the following? (Check all that apply)

- Friends Family School Conduct Others _____

Do you? (Check all that apply)

- Smoke Drink alcohol Use Drugs

Are you sexually active? No Yes

If yes, do you use safe sex practices? No Yes

What type? _____

Do you know the term "PSA"? No Yes

Are you familiar with the term mammogram? No Yes

Are you familiar with the condition involving testicular cancer? No Yes

Vital Signs: Temperature _____ Weight _____
 Pulse _____ Height _____
 Respiration _____
 Blood Pressure _____

Comments: _____

Nurse's Signature _____ Date _____



2009 NATIONAL YOUTH SPORTS PROGRAM FUND
Medical Examination Record
Intended for NYSP Participation Only

This confidential information should be made available only to the medical coordinator and physician.

Enrollee name _____ Telephone _____
Last First Middle

Address _____ M F Age _____
Street Address

_____ Birthdate _____ / _____ / _____
City State ZIP Code Mo. Day Yr.

Name of parent or guardian _____

Address of parent or guardian _____

Telephone: Home _____ Work _____

Emergency Contact

Name _____ Relationship _____

Telephone: Home _____ Work _____

Address _____
Street Address

_____ City State ZIP Code

Family doctor _____ Telephone _____

ATTENTION MEDICAL COORDINATOR:

- Referral:** A youth's parents or guardian must be informed of any health problem discovered during the screening process or during the course of the project. An appropriate health-care agency also will be informed if the parents or guardian consent.
- Follow-up:** When a health problem is discovered, the institution shall pursue the matter until the problem receives proper treatment or until all reasonable opportunities for such treatment have been exhausted. Institutional responsibility for preexisting medical problems or for problems unrelated to NYSP participation ends with the conclusion of the project.

REFERRAL AND FOLLOW-UP PROCEDURE

Parents or guardian and/or health authorities notified of child's health deficiency Yes No

Means of notification: Personal Contact Telephone Letter Date of notification _____

Noticeable improvement as of:

_____	_____	_____
<small>Date</small>	<small>Yes</small>	<small>No</small>
_____	_____	_____
<small>Date</small>	<small>Yes</small>	<small>No</small>

Name of Examining Physician or State Certified Medical Personnel

Address

This confidential information should be made available only to the medical coordinator and physician.

Height _____ Weight _____ Pulse _____ B/P _____

List allergies _____ Hemophilia _____ Other _____

	NORMAL	IF ABNORMAL, DESCRIBE HERE	FOLLOW-UP	
			YES	NO
Ears (hearing, absence or cerumen)				
Eyes (reflexes, movements, visual acuity)				
Nose, Throat, Sinuses				
Gums				
Teeth				
Neck				
Lungs				
Breasts				
Lymph Nodes				
Heart				
Absence of Hernia				
Back				
Skin				
Bones, Joints, Muscles				
Nervous System				

OPTIONAL

Chest X-ray				
Sickle Cell Prep _____	Urine albumin _____	Urine sugar _____	Hb. _____	
Immunization Record:	Tetanus _____ Date _____	Booster Needed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Diphtheria _____ Date _____	Booster Needed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Polio _____ Date _____	Booster Needed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Medical History (including current medications taken): _____ _____ _____				

General physical condition _____

May participate in program Yes _____ No _____

Additional comments or recommendations _____

(If more space necessary, use separate page) Medical Form