HAUPTMAN-WOODWARD
MEDICAL RESEARCH INSTITUTE, INC.

January 1, 2020

To: Parents and Students in the HWI Student Training Program
From: WL Duax
Subject: Parental Consent for Medical Treatment and Safety Acknowledgement

You will soon begin work at the Hauptman Woodward Medical Research Institute (HWI) in a biomedical research laboratory. You will work under the direct supervision of W.L. Duax. We are required to have on file, before you begin the program, a parental consent for Medical Treatment and Safety Acknowledgement. These consents must be received prior to your minor beginning the program.

Individual laboratories vary in the inherent types of hazards present. While working at HWI, your child may encounter some potential hazards. We will take every reasonable measure to mitigate a potential risk to your child. However, you should understand that these risks are present and agree to your child's participation in the program. As part of the work assignment, your child will not be in any designated laboratory space; rather he/she will be working at computers in offices and workstations in common areas of the first floor only. Your child will be instructed not to enter any designated laboratory space, including those where biochemical and chemical studies are being conducted and hazardous materials may be present. HWI provides safety training to employees who work with these materials. More information on HWI's safety training program can be found on our website at www.hwi.buffalo.edu

Please complete the Parental Consent for Medical treatment form that accompanies this letter.

If you have further questions please feel free contact Dr Duax at 716-898-8616.

By signing this memo, you consent to the conditions as outlined above and affirm that you, as the parent or legal guardian, grant permission for Minors Name to work at HWI performing the work as described above.

Minors Name (PRINT): _____
Parent's/Legal Guardian's Name (Print): _____
Parent's/Legal Guardian's Name (Signature):_____
Parent's/Legal Guardian's Phone Number: _____
Date: _____

HAUPTMAN-WOODWARD
MEDICAL RESEARCH INSTITUTE, INC.

Parental Consent for Medical Treatment

Family Physician Information

_____ _____
Name Phone Number

_____
Address

Insurance Information

_____ _____
Company Name Policy Number

Medical Information Please print and be thorough.

Chronic or existing medical conditions
(E.G., Asthma, Seizures, Diabetes)

_____

Anesthetics
Aspirin
Codeine
Demerol
Antibiotics (Please List)

Insect Stings
I.V.P. Dyes
Morphine
Novocaine

Penicillin
Shellfish
Tetanus Toxoid

_____
Other (Please List)

_____

Known Allergies _____

Current Daily Medications

_____

_____

Minors Name (PRINT): _____
Parent's/Legal Guardian's Name (Print): _____
Parent's/Legal Guardian's Name (Signature):_____
Date: _____