

PARENTAL/GUARDIAN CONSENT & MEDICAL AUTHORIZATION

I, the undersigned, am the parent or legal guardian of _____, a minor child, younger than 18 years of age, ("My Child"), whose address is _____. I acknowledge that My Child has been provided with the opportunity to participate in The Summer Research Internship Program (the "Program") on The Florida International University Board of Trustees' ("FIU") MMC, BC, EC Campus in Miami, Florida from June 12, 2026 to August 7, 2026.

I, the parent or guardian of My Child, do hereby authorize that FIU, through its agents or employees, take whatever steps necessary to secure medical treatment for My Child in the event My Child appears to be, at the sole discretion of FIU, in need of such treatment while attending the Program. Furthermore, I understand and acknowledge that by signing this authorization form, I hereby consent to the rendering of all necessary medical treatment to My Child, which may include, but may not be limited to, My Child's admission to a hospital or other appropriate health care facility, in such institutions and at such places as FIU, in its sole discretion, acting through its agents or employees, deems appropriate. I authorize the agents or employees of FIU to execute whatever forms and/or actions which might be necessary to ensure complete and adequate care of My Child and guarantee payment of all charges incurred as a result of any medical treatment or emergency transportation deemed necessary.

By signing this Parental/Guardian Consent & Medical Authorization, I acknowledge and represent that: (i) I have read and understood this document; (ii) I am signing this document voluntarily and for full and adequate consideration, fully intending to be bound by the same; (iii) I am at least eighteen (18) years of age and am of sound mind and body; and (iv) I authorize the release of medical insurance information listed below by FIU to whomever has a need-to-know. I understand that this is a legal document which is binding on me, my heirs, executors, administrators, and assigns and on those who may claim by or through me.

Medical Insurance Company Name

Group Number/Member Number/Plan Number

Parent or Guardian (print name)

Address of Parent or Guardian

Home, Work and Mobile Phone Number(s) of Parent or Guardian

Parent or Guardian Signature

Date