# COURSE WAIVER FORM

Brown University
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Providence, Rhode Island
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Tel 401-863-7900 ; Fax 401-863-3916
Email: summer@brown.edu
**www.brown.edu/summer**

**PARENT/GUARDIAN PERMISSION FOR PARTICIPATION IN COURSE SPECIFIC ACTIVITIES:** Please review the information for the course in which your child/ward is enrolled and check the box next to the course title.

## DNA TESTING ACTIVITY

- ☐ **BI901-3A/3B Techniques in DNA-Based Biotechnology**
- ☐ **BI917-3A Research Techniques in Biomedical Fields**
- ☐ **PY906-3B Genetics and Human Behavior**
- ☐ **SI600-2EA SPARK: So You Want to Be a Scientist**

☐ **Parent/Guardian:** I understand that as part of the courses listed above, each student who elects to do so will conduct an experiment with his/her own DNA. DNA samples will either be collected from cheek cells that normally exist in saliva, in the inside cheek pocket, or from a blood sample. For this experiment the student will perform one of the following: 1. Swish his/her mouth with a saline solution and spit the sample into a cup or, 2. Brush a sterile cotton swab inside his/her mouth along the cheek, or 3. Have approximately 4cc's of blood drawn at Brown Health Services. The DNA samples that are extracted from these cells for this experiment will be amplified and examined for specific DNA markers, which may vary from person to person and play no role in an individual's health nor do they have any relationship to physical traits or characteristics. The DNA markers to be examined have been chosen because they are found in the non-coding portion of the human genome. The information derived from the analysis is the equivalent of ABO Blood Type and is not in any way indicative or predictive of disease. All student DNA samples will be discarded or destroyed with bleach after completing the experiment. I further understand that there is a consensus that human DNA samples should not be obtained without the willing consent of the donor, who understands the purpose for which it is being collected, and that the experiment will be explained beforehand to the student.

☐ I DO give permission for my child/ward to participate in the DNA TESTING ACTIVITY
☐ I DO NOT give permission for my child/ward to participate in the DNA TESTING ACTIVITY

## PERFORM FINGER STICK

- ☐ **BI903-3A So You Think You Want to Be a Doctor: An Introduction to Medicine**

☐ **Parent/Guardian:** I understand that part of course BI903-3A involves some common clinical blood analyses. Under the supervision of trained personnel, each student who elects to do so will stick his/her own finger to obtain blood for various tests. Students will not be allowed to come into contact with the blood or blood products of others. The finger stick must be self administered. Students may elect to perform the same tests without performing the finger stick, but instead using aseptic (sterile) commercial blood samples. Tests performed may include: 1) Blood typing (ABO); 2) Hemoglobin content; 3) Clotting time (hemophilia test). Students will be closely monitored throughout the procedures. The goal of these tests is to learn about the biology upon which the tests are based – not to obtain a diagnostic result.

☐ I DO give permission for my child/ward to participate in the PERFORM FINGER STICK ACTIVITY
☐ I DO NOT give permission for my child/ward to participate in the PERFORM FINGER STICK ACTIVITY

## IMAGING DEPARTMENT AT MIRIAM HOSPITAL

- ☐ **BI903-3A So You Think You Want to Be a Doctor: An Introduction to Medicine**
- ☐ **BI909-1A, 1D So What's Up Doc?**
- ☐ **BI926-1C Exploring Medicine**

**Lab Coat size (Check one): O SMALL O MEDIUM O LARGE O X-LARGE**
**Please note: Lab coats are property of Miriam Hospital and is returned to the Imaging Department after use.**

☐ **Parent/Guardian:** I understand that, as part of the above courses, students will visit the above the Miriam Hospital Imaging Department where ionizing radiation is used.

☐ I give permission for my child/ward to participate in the IMAGING DEPARTMENT ACTIVITY
☐ I DO NOT give permission for my child/ward to participate in the IMAGING DEPARTMENT ACTIVITY

→ **SEE REVERSE SIDE**

## HOSPITAL SHADOWING

- ☐ **BI903-3A So You Think You Want to Be a Doctor: An Introduction to Medicine**
- ☐ **BI909-1A, 1D So What's Up Doc?**
- ☐ **BI926-1C Exploring Medicine**

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|---|---|---|
| Hasbro Children's Hospital<br>Human Resources<br>593 Eddy St.<br>Providence, RI 02903<br>401-444-4562 | The Miriam Hospital<br>Volunteer Office<br>164 Summit Ave.<br>Providence, RI 02906<br>401-793-2510 | Memorial Hospital of RI<br>Volunteer Office<br>111 Brewster St.<br>Pawtucket, RI 02860<br>401-729-2323 |
| Women and Infants Hospital<br>Volunteer Office<br>100 Dudley St.<br>Providence, RI 02905<br>401-276-7802 | Rhode Island Hospital<br>Human Resources<br>593 Eddy St.<br>Providence, RI 02903<br>401-444-4562 | Bradley Hospital<br>Human Resources<br>1011 Veterans Memorial Pkwy<br>East Providence, RI 02915<br>401-432-1113 |

☐ **Parent/Guardian:** I understand that, as part of the above courses, students will visit the above Providence area hospitals or doctor's offices and shadow a physician. I understand that students who shadow physicians must maintain patient confidentiality and assume a professional demeanor at all times. I understand that experiences involving patient contact may result in exposure to blood borne or other pathogens (infections). Students are expected to follow instructions regarding safety and understand that patient contact may entail limited risk.

☐ I give permission for my child/ward to participate in the HOSPITAL SHADOWING ACTIVITY
☐ I DO NOT give permission for my child/ward to participate in the HOSPITAL SHADOWING ACTIVITY

Please enter the Summer Program Course that which your son/daughter/ward is attending:

COURSE CODE __________________ COURSE NAME_____________________________________________________

START DATE _____________________ END DATE ________________________

For the benefit of Brown University, I, the undersigned, acknowledge that my son/daughter/ward is participating in the Summer Program(s) offered by the Office of Continuing Education at Brown University. I understand that my son/daughter/ward's participation in each course and/or activity associated with each course is subject to any and all rules, procedures and regulations; see the ***Policies*** section on our web site, and by Brown University personnel and/or any other person(s) conducting, leading, and/or directing the course/activity. In consideration for allowing my son/daughter/ward to participate in the Summer Programs, I do hereby release and forever discharge Brown University, including the Corporation, its Trustees, faculty, employees, staff, and other agents from all liability and responsibility for any claim or cause of action for any personal injury, accident, damage, expenses or other loss caused, suffered or incurred to my son/daughter/ward during, or arising out of, my son/daughter/ward's participation in each activity or any other person or entity during or arising out of, my son/daughter/ward's participation in the Summer Program. Further, I acknowledge that I have read and understand the above statements and that if I am unable to do so, for whatever reason, I have had them read to me and am confident that the individual has read and/or translated the statements truthfully and in their entirety. This release and waiver has been executed on behalf of myself and my son/daughter/ward, and has been made with full knowledge of possible risks involved. This instrument has been executed in and shall be interpreted according to the laws of the State of Rhode Island.

Parent/Guardian Signature: ______________________________________________ Date: ____________________________

Student Name: ____________________________________________________

### Retain a copy for your records. Please mail to:

Brown University
42 Charlesfield St., Box T
Providence, RI 02912
Attn: Forms Coordinator