Student Lifebook Packet 2016

1) **Read** the Lifebook

2) **Complete** the electronic forms through the BUTI website
   [http://www.bu.edu/cfa/tanglewood/accepted-students/student-life-forms/](http://www.bu.edu/cfa/tanglewood/accepted-students/student-life-forms/)

3) **Print, complete, and sign** the forms in this packet:
   - Residence License Agreement
   - Medical Authorization
   - Activity Waiver Form
   - Report of Medical History
   - Medical Inventory
   - Medical Insurance Information
   - Immunization Record
   - Media Release Form

4) **Print, complete, and sign** these forms **ONLY** if applicable:
   - Psychotropic Provider Report for Attendance at BUTI
   - Anaphylaxis Emergency Plan
   - BSO Beach Waiver (**Must** be signed to use the ‘BSO Beach’)
   - Opening Cookout Ticket Request/Payment Form
   - AIRPORT SHUTTLE Payment Form (**If** requesting)

5) **Mail** hard copy forms/checks prior to May 20\(^{th}\), 2016:
   Mike Westberry, Manager of Operations
   Boston University Tanglewood Institute
   855 Commonwealth Avenue, 2\(^{nd}\) Floor
   Boston, MA 02215

   **SUBMIT/POSTMARK FORMS BY MAY 20, 2016**.*

   *Students who submit late forms will incur a $75 fine. If submitting after May 20\(^{th}\), please mail forms and additional $75 check to: Mike Westberry, Manager of Operations, Boston University Tanglewood Institute, 45 West Street, Lenox, MA 01240.*
Summer 2016 Residence License Agreement

Make a copy of your signed Residence License Agreement for your records.

This Residence License Agreement (Agreement) is for all enrolled programs at the Boston University Tanglewood Institute that you attend during the summer of 2016 (the “Term”). The Term commences on the move-in date outlined in the Tanglewood Institute Lifebook and ends on the move-out date also outlined in the Lifebook.

Student’s full name ____________________________________________  ____________________________________________  ______________________

last  first  middle initial

Date of birth ______/______/______  Sex  □ male  □ female

month  day  year

Home address ____________________________________________________  ____________________________________________________  ____________________________________________________  ____________________________________________________  _________________________________

street

city  state  zip  country

Home telephone (_______) __________________________  Student Cell phone (_______) __________________________

Primary E-mail address __________________________________________

School most recently attended __________________________________________

name  city  state

Last grade/level of degree completed __________

Previous Boston University Tanglewood Institute experience:

Year(s) _________  Workshop/Program(s)/Seminar __________________________________________

I, the undersigned student, apply to become a licensee in the Boston University residential system for the duration of the workshop and/or program(s) for which I am enrolled. I acknowledge receipt of copies of this Residence License Agreement, the Boston University Tanglewood Institute Summer 2016 Lifebook, and the Terms and Conditions of the Residence License Agreement contained within the Lifebook. I agree to be responsible for reading all such documents and revisions and knowing their contents. I hereby agree to comply with the terms and conditions set forth in this Residence License Agreement and the documents incorporated herein by reference, as well as with any subsequent revisions thereof authorized by the University. I further understand that this Residence License Agreement will only be valid if the Student Life Office receives confirmation from the Administrative Office of my acceptance and deposit for the Boston University Tanglewood Institute workshop, program(s), and/or seminar noted above.

________________________________  __________________________

Student’s signature  month  day  year

Date _________/________/________

Guarantor’s signature (If student is under 18 years of age, parent or legal guardian must sign.)  __________________________  __________________________  __________________________

month  day  year
Summer 2016 Medical Authorization

Boston University Tanglewood Institute students and their parents must agree to the conditions set forth below prior to the student’s arrival on campus. Please print and sign.

Student’s full name  ____________________________________  ____________________________________  ______________________
last first middle initial

Date of birth (mm/dd/yy)  ________________________________  ________________________________

Home address  ____________________________________  ____________________________________  __________________________  __________________________
street

city  state  zip  country

BUTI workshop/program(s)/seminar  ________________________________  Dates  ________________________________

Parent’s name  ____________________________________  ____________________________________  ______________________
last first middle initial

Physicians, nurse practitioners, nurses, and other professional staff employed by the Boston University Tanglewood Institute or employed at any medical facility to which the student may be referred by the Boston University Tanglewood Institute are authorized to perform examinations and prescribe and render treatment when consulted by the student. No surgical procedure will be undertaken upon a minor child (under age 18) without prior consent of the parent except in case of emergency. Due to its proximity to Lenox, Berkshire Medical Center is the medical facility to which students are usually referred when acute medical needs arise during the summer program.

When, in the judgment of the physician, a condition exists which should be reported to the parent of a minor child, the parent may be notified after informing the student of the plan to notify the parent. Boston University Tanglewood Institute and any medical facility to which the student may be referred may release medical information or a copy of a minor child’s medical record to the child’s parent, upon appropriate written request by the parent.

Boston University Tanglewood Institute reserves the right to send a student home if it is the judgement of the medical team that the student’s health concerns are beyond what can be supported while in residence at the 45 West Street campus or if it is the judgement of the medical team and administrative staff that the welfare of other community members is at risk.

All medical costs incurred including, but not limited to, ambulance charges, pharmacy costs, hospital emergency room visits, x-rays, laboratory tests, appointments and tests conducted at any medical facility, etc., are the financial responsibility of the parent and/or student. To the extent Boston University Tanglewood Institute pays any medical expenses in connection with the treatment of a student, the parent and/or student shall repay Boston University the full amount of all such charges. If you have medical insurance, you are advised to contact your insurance company for its policies on out-of-area coverage. Students should carry an insurance card (or a photocopy of an insurance card) with them. Please provide your medical insurance information requested below and attach a photocopy of the front and back of your insurance card in the spaces provided. If you do not have insurance, follow the instructions to purchase coverage from Boston University on the medical insurance page of this packet.

Name of insurance company  ________________________________  Policy number  ________________________________

Address  ____________________________________  Policy holder  ________________________________

Pertinent medical information including known allergies and medical conditions which might affect treatment have been disclosed on the Report of Medical History (on reverse side of this authorization), which will be maintained in the files of the health services staff employed by the Boston University Tanglewood Institute.

It is understood that the University assumes no responsibility for providing and/or referring students to medical care in the event the student and/or parent chooses to seek such care independently.

The undersigned hereby acknowledge the above conditions and agree to abide by them during the period the student is enrolled in Boston University Tanglewood Institute, sponsored by Boston University, in June, July, and/or August 2016.

Student’s signature  ____________________________________  Date  ________________________________

Parent’s signature  ____________________________________  Date  ________________________________
For Participation in Boston University Tanglewood Institute Recreational Activities

Name of Student: ________________________________

1. I hereby consent to the participation of the student named above ("Student") in all recreational activities offered by the Boston University Tanglewood Institute ("the Program").

2. I understand, recognize and acknowledge that this Program involves recreational activities in which s/he is not required to participate, including but not limited to swimming and waterfront activities, tennis, lawn sports, basketball, hiking and yoga, that may involve the risk of accident, death, illness, physical or mental injuries, and property damage. It is my responsibility to ask questions about any aspect of the Program’s recreational activities that have not been explained to my satisfaction. I hereby voluntarily assume any and all risks, including injury to person and property, related to the Student’s participation in the Program.

3. In consideration of Boston University allowing the Student to participate in the Program, I, on behalf of myself, the Student, and anyone claiming on behalf of me or the Student hereby FOREVER RELEASE Trustees of Boston University (the “University”) and its departments, officers, directors, board members, representatives, agents, and employees from any and all claims, demands, causes of action, judgment, damages, expenses and costs (including attorneys’ fees), including but not limited to claims of negligence, on account of personal injury, bodily injury, property damage, death or accident of any kind sustained by the Student that arises out of or is related in any way to his/her participation in the Program which I may now or hereafter have and which the above-named Student has or hereafter may acquire, either before or after reaching majority.

4. In signing this Consent and Release from Liability, I hereby acknowledge that I have read this entire document, that I understand its terms, that I have signed it knowingly and voluntarily, and that I intend it to bind me, the Student, and anyone claiming on behalf of me or the Student.

5. I further acknowledge that I am the parent or legal guardian of the Student identified above, with legal authority to sign this document.

PARENT OR GUARDIAN (IF STUDENT IS UNDER 18):

Signature: ________________________________
Name (Printed): ________________________________
Relationship to Student: ________________________________
Street Address: ________________________________
City/State: ________________________________
Telephone: ________________________________

STUDENT (IF STUDENT IS 18 OR OLDER):

Signature: ________________________________
Name (Printed): ________________________________
Relationship to Student: ________________________________
Street Address: ________________________________
City/State: ________________________________
Telephone: ________________________________
Report of Medical History

Please print.

Student’s name _____________________________________ Date of birth (mm/dd/yy) ________________

Parent’s name _____________________________________ _____________________________________

Home telephone (_______) __________________________ Other telephone (e.g., cell, business) (_______) ________________

In case of emergency, alternate contact ________________________________________________

Home telephone (_______) __________________________ Other telephone (e.g., cell, business) (_______) ________________

Name of student’s physician ____________________________________________________________

Physician’s telephone (_______) __________________________

Allergies/Adverse Reactions (Medication, Food or Environmental): ___________________________________________

Has the student been prescribed an Epi Pen? (If so, dose and allergen) ________________________________

CHECK if the student has had any problems in the following areas. Please comment on all checked boxes in the space below.

☐ Childhood Illnesses: (Scarlet Fever, German measles, Mumps, Chicken pox, Rheumatic Fever etc.)
☐ Head/Neurological: (headaches, migraines, seizures, head injury etc.)
☐ Ears, Nose, Throat, Mouth: (ear infections, hearing loss, sinusitis, strep throat, tonsillitis, dental issues, braces etc.)
☐ Eyes: (visual impairment, contact lenses or glasses, infections etc.)
☐ Heart: (palpitations, dizziness, fainting, arrhythmia, high/low blood pressure etc.)
☐ Lung: (shortness of breath, chest pain, asthma, infections, cough etc.)
☐ Musculoskeletal: (broken bones, dislocation, scoliosis, hernia, weakness, paralysis)
☐ Gastrointestinal/Metabolic: (abdominal pain, diarrhea, constipation, recent weight gain or loss, Diabetes, hypoglycemia, gallstones, etc.)
☐ Genital/Urinary: (Urinary tract infections, kidney stones, gynecological problems etc.)
☐ Skin: (rash, eczema, acne, herpes etc.)
☐ Psychological: (ADHD, mood disorder, eating disorder, sleep problems etc.)
☐ Has the student ever been hospitalized?
☐ Has the student ever had surgery?
☐ Does the student have a chronic illness?
☐ Has the student had physical activity restricted during the past five years?
☐ Has the student consulted or been treated by a psychiatrist or mental health provider?
☐ Has the student ever had a positive skin test for tuberculosis (T.B.)?

Comments: Please provide additional information on all checked boxes (diagnosis, treatment, and dates).

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
Medication Inventory

Student’s name ___________________________________________________________ Date of birth (mm/dd/yy) ______________
last                                        first                                   middle initial

Medication includes both prescription and non-prescription medications and includes those taken by mouth or by inhaler, those which are injectable, applied as drops to eyes or nose, or applied to the skin.

PRESCRIPTION MEDICATIONS

If the student is taking psychotropic medication, the prescription must be accompanied by a doctor’s letter attesting that the student is fit to handle the rigorous and often stressful academic environment of BUTI.

All prescription medications must be registered with the Health Services Office. Certain prescription medications may be held and self-administered by the student, but only under the direction of the Health Services Office. However, in order to insure student safety, all psychotropic medications, such as stimulants, antidepressants, anti-anxiety medication, and pain medication must be held and dispensed by the Health Services Office. All prescription medications must also be in original pharmacy containers, labeled by the pharmacy, with the name of the student, the prescribing physician, medication, instructions for use, and the expiration date.

PLEASE LIST PRESCRIPTION MEDICATIONS:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Reason for Use</th>
<th>Directions for Dispensing</th>
<th>Expiration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NON-PRESCRIPTION MEDICATIONS

Students are discouraged from bringing general over-the-counter medications. Health Services provides items such as mild pain relievers, cough suppressants, etc. If students do need to bring special products, please list them below, including all over-the-counter medications, vitamins, skin preparations, herbal items, and food supplements.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Reason for Use</th>
<th>Directions for Dispensing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NO MEDICATION

☐ Please check here to indicate that you will be bringing no medications (including prescription, non-prescription, and herbal supplements).

PARENT ACKNOWLEDGEMENT

By signing below, I acknowledge that I have read the Boston University Tanglewood Institute’s medication policies and agree to comply with them. The responses on this Medication Inventory are true and complete to the best of my knowledge.

Parent’s signature ___________________________________________________________ Date ______________

Student’s signature ___________________________________________________________ Date ______________
Medical Insurance Information

Student's name ____________________________________________ Date of birth (mm/dd/yy)______________
Last ___________ First __________ Middle Initial ________________

Please check one of the following below:

☐ I have insurance and have attached photocopies of the front and back of your medical insurance card in the spaces below.

☐ I do not have insurance and need to purchase it from Boston University for the time period of your residency with us, please check this box and we will be in touch with the Boston University summer insurance plan information. The appropriate form can also be found at: http://www.bu.edu/cfa/tanglewood/accepted/forms/sl
**Immunization Record**

Name of Student: ______________________________________ Date of Birth:__________________

Massachusetts Public Health Law **REQUIRES** every student under the age of 30 to have certified evidence (a signed physician’s record OR official school health record) of the dates of the original series and boosters of the following immunizations in order to register for classes.

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Dates</th>
<th>Month / Day / Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MMR (mumps, measles, rubella)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. First dose on or after 12 months</td>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>b. Second dose (measles required, but MMR preferred)</td>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>2. Diphtheria, Pertussis and Tetanus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Primary Series (please circle type) DTP, DtaP, Dt</td>
<td>1.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>b. Boosters (Last Tetanus needed within 10 years): One Tdap required for residential students:</td>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>3. Polio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Primary Series</td>
<td>1.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>b. Booster</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Hepatitis B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>5. Chicken Pox disease – Date: ________________ or Varivax</td>
<td>1.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>6. Meningococcal (required within 5 years of attendance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Other vaccines: indicate name/date: ____________________________</td>
<td>1.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>8. Tuberculosis testing: A mantoux skin test is required only for students who fall in the following risk categories: work in shelters, nursing homes, or with indigent populations; travel to foreign areas where T.B. is prevalent staying one (1) month or more.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date ________________ mm ________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A chest film is required for any positive PPD. CXR Date ____________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Result: ___________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever received BCG? ________________ If so, when? ____________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been prescribed medication for a positive PPD? ______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If so, dates of Treatment: __________________________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physician Signature________________________________________ Date:______________
Boston University  Tanglewood Institute

Media Release

For Minors Under 18

In connection with programs at the Boston University Tanglewood Institute, I hereby give my permission to the University to photograph, film, videotape, make sound recordings and other recordings of my child (the “Recordings”), to quote or publish the statements of my child and to use any such Recordings, quotations or statements in Boston University educational and promotional/advertising materials. I understand that my child may be identified in any photographs, news stories or publications that Boston University considers appropriate for release to magazines, newspapers, internet publications or other publications and media. I further understand that any such Recordings are the property of Boston University and that they may be copyrighted in the University’s name. I release and discharge the University and its employees and agents from all claims and demands arising out of or in connection with the above-described use of such Recordings, quotations, statements or identifications, including but not limited to any claims for infringement of copyright or invasion of privacy.

I grant the above permissions irrevocably and without payment of compensation, fee or royalty.

I certify that I have read the foregoing, fully understand the contents thereof and agree to these terms.

Child's name (print): ____________________________________________

Parent’s/Guardian’s name (print): ________________________________

Parent’s/Guardian’s signature: ________________________________

Date: ______________

For Adults 18 or Older

In connection with programs at the Boston University Tanglewood Institute, I hereby give my permission to the University to photograph, film, videotape, make sound recordings and other recordings of me (the “Recordings”), to quote or publish my statements and to use any such Recordings, quotations or statements in Boston University educational and promotional/advertising materials. I understand that I may be identified in any photographs, news stories or publications that Boston University considers appropriate for release to magazines, newspapers, internet publications or other publications and media. I further understand that any such Recordings are the property of Boston University and that they may be copyrighted in the University’s name. I release and discharge the University and its employees and agents from all claims and demands arising out of or in connection with the above-described use of such Recordings, quotations, statements or identifications, including but not limited to any claims for infringement of copyright or invasion of privacy.

I grant the above permissions irrevocably and without payment of compensation, fee or royalty.

I certify that I am age 18 or older and have read the foregoing, fully understand the contents thereof and agree to these terms.

Name (print): ____________________________________________

Signature: ____________________________________________

Date: ______________
Psychotropic Provider Report for Attendance to
Boston University Tanglewood Institute

This form is to be completed by the student’s physical or mental health clinician who
prescribes their psychotropic medication, and mailed directly to: Coordinator of Health
Services, Boston University Tanglewood Institute, 45 West St., Lenox, MA 01240

A licensed healthcare provider must complete this form:

Student Name: _______________________________ DOB:___________________
Clinician Name and Degree (printed): ________________________________
Clinician Signature:___________________________ Date: ____________________
Clinician Address: _____________________________________________________
Clinician Phone # ______________________________________________

Dates of Treatment: (from) _______________(to) _______________
Current Diagnosis: Axis I: ________________________________________________
Axis II:_______________________________________________
Current Medications: ___________________________________________________
_____________________________________________________

Please provide your professional judgment in response to the following questions
regarding the above named student.

How long has the student been on this medication and dose and are their symptoms
stable?

__________________________________________________________________

__________________________________________________________________

Are there any anticipated changes that will be made to this regimen for the time the
student is attending BUTI?

YES NO

If “yes”, please explain:

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

This student is ready to engage in the unstructured, unsupervised and demanding
residential academic environment at BUTI on a full-time basis for the summer months:

YES NO

Comments:

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________
Anaphylaxis Emergency Plan: ___________________________ (name)

This person has a potentially life-threatening allergy (anaphylaxis) to:

- Peanut
- Tree nuts
- Egg
- Milk

(Check the appropriate boxes.)
- Other: __________________________________________

Food: The key to preventing an anaphylactic emergency is absolute avoidance of the allergen. People with food allergies should not share food or eat unmarked / bulk foods or products with a “may contain” warning.

Epinephrine Auto-Injector: Expiry Date: _________________ / _________________

Dosage:
- EpiPen® Jr 0.15 mg
- EpiPen® 0.30 mg
- Twinject® 0.15 mg
- Twinject® 0.30 mg

Location of Auto-Injector(s):

- Previous anaphylactic reaction: Person is at greater risk.
- Asthmatic: Person is at greater risk. If person is having a reaction and has difficulty breathing, give epinephrine auto-injector before asthma medication.

A person having an anaphylactic reaction might have ANY of these signs and symptoms:

- Skin system: hives, swelling, itching, warmth, redness, rash
- Respiratory system (breathing): coughing, wheezing, shortness of breath, chest pain/tightness, throat tightness, hoarse voice, nasal congestion or hay fever-like symptoms (runny, itchy nose and watery eyes, sneezing), trouble swallowing
- Gastrointestinal system (stomach): nausea, pain/cramps, vomiting, diarrhea
- Cardiovascular system (heart): pale/blue colour, weak pulse, passing out, dizzy/lightheaded, shock
- Other: anxiety, feeling of “impending doom”, headache, uterine cramps, metallic taste

Early recognition of symptoms and immediate treatment could save a person’s life.

Act quickly. The first signs of a reaction can be mild, but symptoms can get worse very quickly.

1. Give epinephrine auto-injector (e.g. EpiPen® or Twinject®) at the first sign of a known or suspected anaphylactic reaction. (See attached instruction sheet.)
2. Call 9-1-1 or local emergency medical services. Tell them someone is having a life-threatening allergic reaction.
3. Give a second dose of epinephrine in 5 to 15 minutes IF the reaction continues or worsens.
4. Go to the nearest hospital immediately (ideally by ambulance), even if symptoms are mild or have stopped. The reaction could worsen or come back, even after proper treatment. Stay in the hospital for an appropriate period of observation as decided by the emergency department physician (generally about 4 hours).
5. Call emergency contact person (e.g. parent, guardian).

Emergency Contact Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The undersigned patient, parent, or guardian authorizes any adult to administer epinephrine to the above-named person in the event of an anaphylactic reaction, as described above. This protocol has been recommended by the patient’s physician.
How to use EpiPen® and EpiPen® Jr Auto-injectors.

Remove EpiPen® Auto-injector from carrier tube

1. Hold firmly with orange tip pointing downward
2. Remove blue safety release

- Swing and push orange tip firmly into mid-outer thigh until you hear a ‘click’
- Hold on thigh for several seconds

Built-in needle protection
- When the EpiPen® Auto-injector is removed, the orange needle cover automatically extends to cover the injection needle

After administration, patients should seek medical attention immediately or go to the emergency room. For the next 48 hours, patients must stay within close proximity to a healthcare facility or where they can call 911.

For more information go to www.EpiPen.ca
BOSTON SYMPHONY ORCHESTRA

ACKNOWLEDGMENT AND WAIVER OF LIABILITY

I would like to participate in swimming and waterfront activities offered at the “BSO Beach” in Tanglewood. This is an optional, elective, extra-curricular activity being offered to Boston University Tanglewood Institute students, for which I will not be receiving academic credit. My participation in this activity is a voluntary decision on my part.

I acknowledge that I am aware that there are risks to me of injury entailed in my participation in swimming and waterfront activities. I understand that these activities may be physically challenging and potentially dangerous, including the risk of hypothermia and drowning. I do fully and completely assume any risks solely to myself, and accept full responsibility for my individual physical fitness to participate in these activities. I further agree that I will comply with all the Boston University and Boston Symphony Orchestra Tanglewood waterfront rules, and that I will not be under the influence of any chemical substance, including alcohol, while participating in these activities. I understand that the University gives no assurances or warranties whatsoever as to the safety of participants in swimming and waterfront activities.

In consideration of being presented the opportunity to participate in swimming and waterfront activities and in acknowledging that I am aware of and willing to assume the risks associated with these activities, I hereby voluntarily agree to waive, hold harmless and indemnify the Boston Symphony Orchestra, the Trustees of Boston University and its trustees, agents, volunteers and employees from any and all claims, demands, damages and causes of action of any nature whatsoever arising out of ordinary negligence which I, my heirs, my assigns or successors may have against them for, on account of, or by reason of my participation in swimming and waterfront activities offered at the “BSO Beach” in Tanglewood. I understand the content of this document, and I execute this GENERAL RELEASE, WAIVER OF CLAIM AND ASSUMPTION OF RISK AGREEMENT of my own free will and accord.

NAME (Print):____________________________________________________________

DATE:________________SIGNATURE:_______________________________________

PARENT OR GUARDIAN SIGNATURE:_____________________________________

(If under 18 years of age)
Students, families and friends are cordially invited! The opening cookouts are held on the back lawn of Groton Place, West Street Campus, and are served buffet-style. Students' meals are already included in the summer residence board. Tickets to the cookouts are available to students' guest(s) at a cost of $10.00 each. Advance reservations are preferred to ensure food is available.

Cookouts will follow the opening ceremonies on Sunday, June 19, 2016 and Sunday, July 3, 2016 at approx. 5:30 p.m.

Please complete this form and attach a separate, nonrefundable check made payable to 'Boston University.' On the check, write the name of the student with whom the guest(s) will be accompanying. Include this form and your check with your completed Housing Forms.

Reserved tickets will be distributed at housing registration on the days of the cookouts. If guests plan to attend more than one cookout, please indicate the number of guests who will attend on each date.

Student’s name ________________________________________________________________

last first middle initial

• **Sunday, June 19, 2016**: Number of guests _________ x $10.00

• **Sunday, July 3, 2016**: Number of guests _________ x $10.00

**Total enclosed** _______________

($10.00 per person)

Please attach your check here (Do NOT Staple)
Boston University Tanglewood Institute

Albany Airport Shuttle

Payment Form

Students who signed up for any of the airport shuttles through the electronically submitted forms need to complete this form to make payment. The airport shuttle cost $45 one-way and $90 roundtrip.

If paying by check, attach a separate, nonrefundable check made payable to ’Boston University.’ On the check memo, write the name of the student and “shuttle fee.” Include this form and check with your other completed forms.

Student’s Name ____________________________________________________________

Last  First  Middle Initial

Check the approx. arrival shuttle from Albany Airport to West Street Campus for which you signed up:

☐ Sunday, June 19  10:30 a.m. departure from Albany
☐ Sunday, June 19  2:30 p.m. departure from Albany
☐ Sunday, July 3  10:30 a.m. departure from Albany
☐ Sunday, July 3  2:30 p.m. departure from Albany
☐ Sunday, July 24  TBA, departure from Albany (Piano Session 2 Only)

Check the approx. departure shuttle from West Street Campus to Albany Airport for which you signed up:

☐ Saturday, July 2  9:00 a.m. departure from Campus
☐ Saturday, July 2  4:30 p.m. departure from Campus
☐ Sunday, July 3  8:00 a.m. departure from Campus (YAOI Students Only)
☐ Saturday, July 23  TBA, departure from Campus (Piano Session 1 Only)
☐ Monday, August 1  8:00 a.m. departure from Campus
☐ Saturday, August 13  Immediate departure after YAO concert (app. 4:30 p.m.)
☐ Sunday, August 14  7:00 a.m. departure from Campus

Please note that both the arrival and departure BUTI shuttle schedules are subject to change. Should any changes be made and you have requested a seat, we will let you know of any change in service.

Total enclosed: ______________________  Student’s Name: __________________________________

($45/trip or $90 roundtrip)

Please attach your check here or, if using a credit card, complete the following:

Please charge my shuttle fee in the amount of $ ______ to my credit card:

__ AMEX  __ Visa  __ MasterCard  __ Discover

Name on card: _____________________________________________________________

Credit card number: ______________________________________________________

Signature ________________________  Exp. Date ______

You should never email information containing credit card data. PLEASE NOTE THAT BOSTON UNIVERSITY IS UNABLE TO ACCEPT THIS FORM VIA EMAIL.