



## **WORKSHOP APPLICATION**

**2009**

### **Checklist**

- Texas Student Television Workshop 2009**
- Memorandum**
- Release and Indemnification Agreement**
- Authorization for Release of Medical Information**
- Consent for Treatment of a Minor**
- Notice of Privacy Practices**
- Workshop Registration**

**Texas Student Television  
High School Workshop 2009**

***Texas Student Television is the student television station at The University of Texas. Counselors for the camps will consist of award winning Broadcast Journalism and Radio-Television-Film majors who work at TSTV.***

**When:**

**Session 1 - Production Workshop: June 22 – June 26**

**Session 2 - News Workshop: July 20 – 24**

**Time: 9am - 4pm**

**Cost: \$400/person per session (Faculty & Staff receive 20% off)**

**Age: Incoming 9<sup>th</sup>, 10<sup>th</sup>, 11<sup>th</sup>, and 12<sup>th</sup> graders.**

**Extras: Lunch, T-shirt**

**Location:**

**Texas Student Media**

**Walter Webb Hall**

**405 W. 25th Street**

**Austin, TX 78705**

**Lunches: Mix of both hot and cold lunches (ex. sandwiches or pizza).**

**\*Journalism Workshop**

**Learn all about TV news; how to write, shoot, and edit. Students will produce a news show that will air on TSTV and Time Warner Cable Channel 16.**

**\*Production Workshop**

**Learn how to produce a movie review program or a music video show, like MTV or VH1. Students will produce a show that will air on TSTV and Time Warner Cable Channel 16 at the end of the week.**

***\*Registration forms available at the Texas Student Media business office, 2500 Whitis Avenue, 8am to 5pm. Contact the business office 471-5083 or email questions and registration form request to Dan Knight at [DanKnight@mail.utexas.edu](mailto:DanKnight@mail.utexas.edu)***

THE UNIVERSITY OF TEXAS AT AUSTIN  
*UNIVERSITY SPONSORED Workshop*  
*Television Workshop*  
*TSTV, Texas Student Media*

**M E M O R A N D U M**

**Date: SUMMER 2009**

**To: Parents/Guardians of Prospective Campers**

**FROM: TSTV, Texas Student Media**

**RE: REQUIRED MEDICAL FORMS**

TSTV, a unit of Texas Student Media, wishes to welcome your son/daughter as a camp participant. Every camp carries with it some small degree of risk to the participant because of the nature of the activities, for example the normal injuries which come from participation in sports and other activities. To facilitate your child's care, we are requesting that you complete a number of health status and medical release forms. Campers will not be permitted to participate in any activities until all forms are completed and are on file with the camp supervisors. The following forms are attached for your review and completion:

**WAIVER AND RELEASE AGREEMENT**

**CONSENT FOR TREATMENT OF A MINOR**

**PRE-ACTIVITY CLEARANCE PHYSICAL EXAMINATION:**

**PHYSICIAN AUTHORIZATION**

*All campers are required to have written physician clearance proclaiming them fit for camp participation. The physical examination must have been completed within the last 12 months. If your physician has documented the health information on another form, a copy of this form will suffice and can be attached to the back page of the booklet.*

**THE UNIVERSITY OF TEXAS AT AUSTIN**  
**UNIVERSITY SPONSORED Workshop**  
**Television Workshop**  
**TSTV, Texas Student Media**

**RELEASE AND INDEMNIFICATION AGREEMENT**

**PARTICIPANT: (Name and Address)**

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**INSTITUTION:**

*The University of Texas at Austin*

**DESCRIPTION OF ACTIVITY: Television Workshop– TSTV**

**PLEASE IDENTIFY SESSIONS: A B**

**LOCATION: Location: Texas Student Media Walter Webb Hall  
405 W. 25th Street Austin,Tx 78705**

**DATE(S): June 22 – June 26, July 20 – 24**

I am the Parent/Guardian of the above-named Participant who is under eighteen years of age and am fully competent to sign this Agreement.

In consideration of Participant being permitted to participate in the Activity and to use the program's facilities and equipment, I hereby accept all risk to Participant's health and of his/her injury or death that may result from such participation. I hereby release the above named Institution, its governing board, officers, employees and representatives from any and all liability to Participant, Participant's personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to Participant's property and for any and all illness or injury to Participant's person, including his/her death, that may result from or occur during Participant's participation in the Activity, whether caused by negligence of the Institution, its governing board, officers, employees, or representatives, or otherwise. I further agree to indemnify and hold harmless the Institution and its governing board, officers, employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from Participant's negligent or intentional act or omission while participating in the described Activity.

**I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE A RELEASE OF ALL CLAIMS AND CAUSES OF ACTION FOR PARTICIPANT'S INJURY OR DEATH OR DAMAGE TO PARTICIPANT'S PROPERTY THAT OCCURS WHILE PARTICIPATING IN THE DESCRIBED ACTIVITY AND IT OBLIGATES ME TO INDEMNIFY THE PARTIES NAMED FOR ANY LIABILITY FOR INJURY OR DEATH OF ANY PERSON AND DAMAGE TO PROPERTY CAUSED BY PARTICIPANT'S NEGLIGENT OR INTENTIONAL ACT OR OMISSION.**

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**Signature of Parent/Guardian Signature of Witness**

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**Address (if different than Participant's)**

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**Date Signed**

THE UNIVERSITY OF TEXAS AT AUSTIN  
*UNIVERSITY SPONSORED Workshop*  
*Television Workshop*  
*TSTV, Texas Student Media*

**PRE-ACTIVITY CLEARANCE EXAMINATION:  
PHYSICIAN AUTHORIZATION**

I hereby certify that I have examined (*student*) \_\_\_\_\_ and have found him/her fit to attend and participate in the *Television Workshop*. I know of no impairments, which would limit his/her participation in all camp activities except those that I have listed below. I further certify that he/she is free from any and all contagious diseases.

**Restrictions and/or Comments:**

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**Date of Last Tetanus Booster:** \_\_\_\_\_

**Date of Physical Examination (must have been completed within the last 12 months)**

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**Physician's  
Signature:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State,  
Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**THE UNIVERSITY OF TEXAS AT AUSTIN  
UNIVERSITY SPONSORED Workshop  
Television Workshop  
TSTV, Texas Student Media**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO CAMP STAFF**

**This authorizes The University of Texas at Austin physicians, medical personnel and camp sponsors to release relevant information concerning the medical status, medical condition, injuries, prognosis, diagnosis and related personally identifiable health information \_\_\_\_\_ (Participant) to camp staff. This information includes injuries or illnesses relative to participation in the above named camp at The University of Texas at Austin.**

**The reason for this disclosure is to advise the camp staff of the nature, diagnosis, prognosis or treatment concerning any medical condition, injuries or illnesses Participant may have so that they may make decisions regarding Participant's ability and suitability to participate in camp activities. I understand that the entities that receive the information are not health care providers or health plans covered by federal privacy regulations, and that the information described above may be re-disclosed publicly and that the information will no longer be protected by those regulations.**

**I understand that The University of Texas at Austin will not receive compensation for its use/disclosure of the information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain medical treatment. I may inspect or copy any information used/disclosed under this authorization.**

**I understand that I may revoke this authorization in writing at any time by notifying in writing Mary Felps at Texas Student Media, but if I do, it will not have any effect on actions The University took in reliance on this authorization prior to receiving the revocation. This authorization expires six months from the date it is signed.**

\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

\_\_\_\_\_  
**Date**

**THE UNIVERSITY OF TEXAS AT AUSTIN**  
**UNIVERSITY SPONSORED Workshop**  
**Television Workshop**  
**TSTV, Texas Student Media**

**CONSENT FOR TREATMENT OF A MINOR**  
(Please Print or Type)

Name of Camper: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of  
Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_  
Phone Number(s): \_\_\_\_\_  
Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

I, the undersigned, as the parent or legal guardian of (a minor) hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending physician, appropriate staff, and The University of Texas at Austin and its officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

I have received a copy of University Health Services *Notice of Privacy Practices*.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

**PERTINENT MEDICAL/INSURANCE INFORMATION(to be completed by parents/guardians)**

**Medical:**  
**Allergies:** \_\_\_\_\_  
**Current Medications:** \_\_\_\_\_  
**Other:** \_\_\_\_\_

**Insurance:**  
**Company:** \_\_\_\_\_

**Policy #:** \_\_\_\_\_  
**Social Security or ID #:** \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES  
UNIVERSITY OF TEXAS AT AUSTIN  
UNIVERSITY HEALTH SERVICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO HIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

**HIPAA PRIVACY RULES REQUIRE THAT WE FURNISH YOU WITH THIS NOTICE.**

**I. Purpose: University Health Services and its professional staff, employees, and volunteers follow the privacy practices described in this Notice. UHS maintains your medical information in records that will be maintained in a confidential manner, as required by law. However, UHS must use and disclose your medical information to the extent necessary to provide you with quality health care. To do this, UHS must share your medical information as necessary for treatment, payment, and health care operations.**

**II. What Are Treatment, Payment, and Health Care Operations?**  
**Treatment includes sharing information among health care providers involved in your care. For example, your physician may share information about your condition with the pharmacist to discuss appropriate medication, or with radiologist or other consultants in order to make a diagnosis. UHS may use your medical information as required by your insurer to obtain payment for your treatment. We also may use and disclose your medical information to improve the quality of care, e.g., for review and training purposes.**

**III. What Are Other Ways UHS May Use Your Medical Information? You medical information may be used, unless you ask for restrictions on a specific use of disclosure for the following purposes:**

- Appointment reminders.
- To inform you of treatment alternatives or benefits or services related to your health. (You will have an opportunity to refuse to receive this information.)
- To carry out health care treatment, payment, and operations functions through business associates, e.g., to install a new computer system.
- Worker's Compensation. (Your medical information regarding benefits for work-related illnesses may be released as appropriate.)
- Health oversight activities, e.g., audits, inspections, investigations, and licensure.
- Certain research projects.
- To prevent a serious threat to health or safety.
- Law enforcement (e.g., in response to a court order or other legal process; to identify or locate an individual being sought by authorities; about the victim of a crime under restricted circumstances; about a death that may be the results of criminal conduct; circumstances relating to reporting information about a crime.)
- Disaster relief agency if injured in a disaster.
- National security and intelligence activities.
- Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.
- Lawsuits and disputes. (We will attempt to provide you advance notice of a subpoena before disclosing the information.)
- As required by law.

**IV. Your Authorization Is Required for Other Disclosures. Except as described above, we will not use or disclose your medical information unless you authorize (permit) UHS in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation.**

**V. You Have Rights Regarding Your Medical Information. You have the following rights regarding your medical information, provided that you make a written request to invoke the right on the form provided by UHS.**

- **Right to request restrictions.** You may request limitations on your medical information we use or disclose for health care treatment, payment, or operations (e.g., you may ask us not to disclose that you have had a particular surgery), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency services.
- **Right to confidential communications.** You may request communication in a certain way or at a certain location, but you must specify how or where you wish be contacted.
- **Right to inspect and request a copy.** You have the right to inspect and request a copy your medical information regarding decisions about your care. We charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by UHS. UHS will comply with the outcome of the review.
- **Right to request amendment.** If you believe that the medical information we have about you is incorrect or incomplete, you may request an amendment on the form provided by UHS, which requires certain specific information. UHS is not required to accept the amendment.
- **Right to accounting disclosures.** You may request list of the disclosures of your medical information that have been made to persons or entities other than for health care treatment payment or operations in the past six (6) years, but not prior to April 14, 2003. After the first request, there will be a charge.
- **Right to copy of this Notice.** You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this Notice at our web site, <http://www.utexas.edu/student/health/>.

**VI. Requirements Regarding This Notice.** UHS is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. UHS may change this Notice and these changes will be effective for medical information we have about you as well as any information we receive in the future. Each time you register at UHS for health care services, you may receive a copy of the Notice in effect at the time.

**VII. Complaints.** If you believe your privacy rights have been violated, you may file a complaint with UHS or with the Secretary of the United States Department of Health and Human Services. You will not be penalized or retaliated against in any way for making a complaint to UHS or the Department of Health and Human Services

**Contact: Call the UHS HIM Administrator at (512) 475-8432 if:**

- **You have a complaint.**
- **You wish to obtain a form to exercise your individual rights described in paragraph V.**
- **You have any questions about this Notice.**
- **You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations.**

P.O. Box D \* Austin, TX 78713-8904  
Campus Mail Code: E4100  
(512) 471-7899 \* (512) 232-5793 fax

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## Workshop Registration

Participant's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Phone Number & Contact Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Age: \_\_\_\_\_

Session(s): \_\_\_\_\_ Total Package Cost: \_\_\_\_\_

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### Packages:

**Session 1: Production Workshop: June 22 – June 26, 2009: \$400/person\***

- Each package comes with a daily lunch, T-shirt, and DVD copy of the Participant's television broadcast that will be mailed to the address provided above.
- Faculty & Staff receive 20% discount (\$320/person\*)

**Session 2: Journalism Workshop: July 20 - 24, 2009: \$400/person\***

I authorize TSTV to schedule and broadcast \_\_\_\_\_ name and  
image on TSTV. *Participants Name*

\_\_\_\_\_  
Parent/Child guardian/representative (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date