

**JACKSON STATE UNIVERSITY
STUDENT TRAVEL REQUEST FOR AUTHORIZATION**

Part I. Requestor/Sponsor/Organization Information

Name of University Faculty/Staff Member Responsible for Trip: _____

Position /Title: _____

Administrative Unit/Organization: _____

Phones: Office _____ Cell _____ Email _____

Part II. Student Information

Please attach a roster with J#, name, address, phone number(s), email address, and emergency contact information for each participant.

Part III. Travel Information

Reason for Travel: _____

Destination: _____

Dates of Travel: Departure: _____ Return: _____

Total Number of Participants: _____ Attach list of Names for group activity only

Number of Non-Student Participants: _____ Attach list of Names for group activity only

Transportation Arrangements (Check one):

Rental Car _____ Personal Car _____

University-Owned Vehicle _____ Common Carrier _____

Name(s) of Drivers: _____

Lodging Arrangements (Address and Phone Number Required):

Phone: _____

Part III. Required Information/Documents:

Please check all applicable items that have been documented and filed:

_____ List of All Participants/Emergency Contacts (Attached)

_____ Release/Indemnification Agreements

_____ Proof of Medical Insurance

_____ Medical/Emergency Treatment Authorization Forms

Name of University Employee Not Traveling Available for Contact in the

Case of Emergency: _____

Phones: Office _____ Home _____ Cell _____

Part IV. Administrative Approval

Sponsor Signature/Title/Date: _____

Department Chair Signature/Date: _____

Academic Dean Signature/Date: _____

Provost & Sr. VP for Academic Affairs/Date: _____

(Academic Units Only)

Dean of Students Signature/Date: _____

Vice President of Student Life Signature/Date: _____

JACKSON STATE UNIVERSITY | DEAN OF STUDENTS OFFICE
STUDENT TRAVEL ROSTER

INSTRUCTIONS: PLEASE FILL OUT FORM (COLUMNS 1-4 ONLY) AND RETURN TO THE DEAN OF STUDENTS OFFICE, AT LEAST ONE MONTH PRIOR TO YOUR TRAVEL DATE. INCOMPLETE TRAVEL PACKETS/ DOCUMENTS WILL NOT BE ACCEPTED OR APPROVED.

Name of Department or Organization _____ Date of Travel _____ Travel Location _____

Faculty/Staff Traveler _____ Faculty/Staff Phone Number _____ Faculty/Staff Email _____

J-Number	First Name	Last Name	Student Type	Registration Clearance		Conduct Clearance	
				YES	NO	YES	NO
Ex: J00142523	Fred	Smith	Undergraduate	YES	NO	YES	NO
Ex: J00142523	Jackie	Nash	Graduate Student	YES	NO	YES	NO
				YES	NO	YES	NO
				YES	NO	YES	NO
				YES	NO	YES	NO
				YES	NO	YES	NO
				YES	NO	YES	NO
				YES	NO	YES	NO
				YES	NO	YES	NO
				YES	NO	YES	NO

Signature (Student Affairs Staff Member) Date

Signature (Dean of Students Office Staff) Date

JACKSON STATE UNIVERSITY
STUDENT RELEASE AND INDEMNIFICATION AGREEMENT

In consideration of the opportunity to participate and/or travel for _____ and to receive the benefit of services rendered by the Administrators, faculty, staff, agents, and other representatives of Jackson State University, the undersigned hereby acknowledges and agrees as follows:

I acknowledge that activities conducted in the course of the program, event, activity, or travel may entail known or unanticipated risks which could result in harm to me or third parties or damage to property.

I certify that I have no medical physical conditions which could interfere with my safety or the safety of others in connection with my participation in the activity, and I hereby assume and agree to bear the costs of all risks that may be created, directly or indirectly, by any such condition, whether or not disclosed to the University. My participation in the activity is purely voluntary.

I understand that this release is related to non-essential services, and I have the choice not to sign the release. However if I choose not to sign it, I cannot participate in the non-essential activity or program. Nonessential activities include those which a person has or had the option not to participate, and this specifically includes transportation provided by anyone, including myself. I agree that other options are available to me aside from the one that requires this release. Potential other options include, but are not limited to, finding alternate forms of transportation, not participating in the nonessential event, and purchasing insurance for personal property or other harm rather than attempting to hold Jackson State University or its employees responsible for any such damages.

I HEREBY VOLUNTARILY RELEASE, INDEMNIFY, AND FOREVER DISCHARGE THE UNIVERSITY, AS WELL AS ALL COMMUNITY PARTNER AGENCIES, THEIR EMPLOYEES, OFFICERS, AGENTS, AND ASSIGNS, ON BEHALF OF MYSELF, MY CHILDREN, MY PARENTS, MY HEIRS, ASSIGNS, PERSONAL REPRESENTATIVES, AND ESTATE FROM ANY AND ALL CLAIMS, DEMANDS, OR CAUSES OF ACTION WHICH IN ANY WAY RELATE TO OR ARISE OUT OF MY PARTICIPATION IN THE PROGRAM/ACTIVITY OR MY USE OF THE UNIVERSITY'S EQUIPMENT OR FACILITIES, INCLUDING ANY SUCH CLAIMS ALLEGING NEGLIGENT ACTS OR OMISSIONS OF THE UNIVERSITY. I AGREE NOT TO DEMAND OR BRING ANY LEGAL ACTION, ON BEHALF OF MYSELF OR ANY DEPENDENT, AGAINST THE UNIVERSITY OR ITS AGENTS ARISING FROM MY PARTICIPATION IN THE EVENT, ACTIVITY, OR PROGRAM.

I am eighteen (18) years of age or older and am competent to execute this agreement. If the participant is not eighteen (18) years of age, this release must also be signed by a parent or guardian.

Print Name: Date: _____

Signature: _____

Parent/Guardian Name: Date: _____

Parent/Guardian Signature: _____

(Only if Student is not eighteen (18) years of age.) _____

JACKSON STATE UNIVERSITY
STUDENT AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I. MEDICAL INFORMATION (please type or print legibly)

a. Name: _____

Address: _____

Telephone Number: Day: Evening: _____

b. Name of Nearest Relative (or guardian if student is under 18 years of age):

Address: _____

Telephone Number: Day: Evening: _____

c. Physician's Name: _____

Address: _____

Telephone Number: Office: Emergency: _____

d. Dentist's name: _____

Address: _____

Telephone Number: Office: Emergency: _____

e. Health Insurance Company Name: _____

Policy Number: Telephone: _____

f. Allergies: _____

g. Current Medications: _____

h. Special Health Needs: _____

II. EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned, do hereby authorize Jackson State University and its agents or representatives to consent, on my behalf, to any medical/hospital care or treatment (including locations outside the U.S.) to be rendered upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

The effective dates of this authorization are _____ to _____. I am eighteen (18) years of age or older, have read the above authorization, and confirm that the information contained therein is true and accurate. (*If the participant is not eighteen (18) years of age or older, this release must be signed also by a parent/guardian.)

Date: _____

(Signature of Individual) _____/Date: _____

(Signature of Parent or Guardian if student is not eighteen (18) years of age)
