



Medical Emergency Information and Release 2022-2023

Student Name (PRINTED): _____

I hereby grant Community Autism Resources' Gottschall Access Program and its agents full authority to take whatever actions they may consider to be warranted under the circumstances concerning my health and safety, and I fully release them from any liability for such decisions or actions as may be taken in connection therein.

**Student Pledge
Behavior and Responsibility**

I understand that Gottschall Access students are expected to demonstrate mutual respect for one another and for other members of the college community. Personal or sexual harassment, or behavior which does not respect the rights of others, will not be tolerated. As a member of the college community, I agree to respect other people and their property at all times.

I agree to comply fully with the rules of the Gottschall Access Program (GAP) and Bristol Community College and its agents. I understand that if I jeopardize the health and safety of myself or others, or if my behavior interferes with other students' right to learn or instructors' right to teach, GAP/ Community Autism Resources has the right to terminate my participation in the Gottschall Access Program with no refund of monies paid. I also understand that violent behavior will result in automatic dismissal.

Students of GAP through Bristol Community College have many services and opportunities available, including for example, the use of adaptive equipment, tutoring, computer labs, and the opportunity to join college clubs and activities. I understand that my instructor or advisor may assist me, but as a college student, it is my responsibility to access these resources and follow through.

Student's Signature Date

Parent/Guardian Signature Date

Required only if student has a legal, court-appointed guardian and must submit documentation

IF PARENT/GUARDIAN IS A COURT-APPOINTED GUARDIAN, YOU MUST SUBMIT LEGAL DOCUMENTATION

**** COMPLETE BOTH SIDES****



Authorization for Release of Information 2022-2023

Student Name (PRINTED): _____

I understand that the Gottschall Access Program (GAP) requires certain medical and individual learning style information in order to provide services and develop my educational program. All information that GAP receives will be used for purposes connected with my educational program and shall be confidential.

I authorize the release of information to the Gottschall Access Program for purposes of educational instruction and employment. I also authorize the Gottschall Access Program to release information to designated individuals, agencies, hospitals, institutions, and facilities listed below for purposes of educational planning, vocational instruction, and employment.

I understand that I may withdraw this authorization for any one of these resources at any time by giving written notice to the Gottschall Access Program.

Approved Sources: **CHECK ALL THAT APPLY.** YOU WILL BE CONSULTED BEFORE ANY INFORMATION IS RELEASED.

- Department of Mental Health
- Department of Public Health
- Division of Employment Security
- Rehabilitation, Human Services, and Employment Agencies
- Public and Private Hospitals
- Public and Private Schools and Colleges
- Public and Private Mental Health Centers
- Drug and Alcohol Clinics
- Department of Children and Families
- Department of Developmental Services
- Massachusetts Rehabilitation Commission
- Veterans Administration
- Independent Living Centers
- Psychiatrists, Psychologists, Physicians and other Health Care Professionals
- Employers
- Commission for the Deaf and Hard of Hearing
- Commission for the Blind
- Statewide Head Injury Program
- Other _____

Exceptions or Additions to above list: _____

 Student's Signature

 Date

Do you have a legal guardian? YES (see below) NO
 If **YES**, please submit legal documentation and have guardian sign below.

 Parent/Guardian Signature

 Date

Required if student has a legal, court-appointed guardian and must submit documentation.