National Aeronautics and Space Administration

Emergency Medical Authorization

Dropping In a Microgravity Environment (DIME)

(Completion of form is required for processing of application.)

Full legal name of student _____ _____ _____

Last name, suffix (e.g., Jr.) *First name* *Middle name*

Date of birth _____ *mm/dd/year (e.g., 11/14/1992)*

Gender ◯ Female ◯ Male

Address _____

Home telephone number _____

Name of parent/legal guardian _____

Telephone number where parent or guardian can be reached between 8:00 a.m. and 5:00 p.m. _____

Name, telephone number(s), and relationship of other custodial parent or emergency contact.

_____

Facts concerning the student's medical history to which the physical should be alerted:

Allergies _____

Medications taken _____

Physical impairments _____

Other _____

In the event that reasonable attempts to contact one of the parents of, or the legal guardian of, the above minor are not successful, I hereby give my consent to the administration of medical treatment deemed necessary by the Medical Services Office at the NASA Glenn Research Center. In the event that more extensive medical care is necessary than that given by the Glenn Medical Services Office, I authorize the transfer of the minor to a local hospital by ambulance.

_____ _____

Signature of parent/guardian *Date*