



Dear Parent/Guardian:

Your child has been invited to apply for ***Metrotown Institute***, an *experiential teen diversity program* specially designed for future leaders to elevate levels of awareness and understanding, thus bridging gaps across differences. The interactive leadership program includes a weekend-long concentrated adaptation of Metrotown Institute, a four-day OneJax program for high school students held each summer that promotes respect and understanding across the differences in race, religion, sexual orientation, gender, ethnicity, socio-economic status, and ability. OneJax will hold the leadership learning lab from Friday, December 18 to Sunday, December 20, 2020. Students will participate in group experiences/activities during the workshops, facilitated discussion sessions, and individual reflection while earning 24.5 hours of community service. Metrotown is a powerful experience that lights a spark and impacts all.

There are several benefits for students that participate in ***Metrotown Institute***. They learn the origins and manifestation of diversity while developing skills that will enable them to facilitate dialogues around difference. The ***Metrotown*** program also strengthens leadership skills, such as decision-making and collaborating with others, relevant to success in adulthood as community leaders. By participating in ***Metrotown***, we aim to prepare students for an increasingly diverse society by building a tradition of tolerance, acceptance, and respect for others. All participants have an opportunity for community service hours.

We seek your permission for your child's participation in ***Metrotown***. Please sign the attached consent form, noting whether you will allow your child to be photographed and videotaped. If you have any questions or concerns, please contact us, and we will gladly assist you.

Thank you in advance for your support.

*Deidre M. Lane*

Deidre Lane, Associate Director of Programs  
OneJax Institute  
(904) 620-1529 or 620-5608

*Note: CDC guidelines will be adhered to due to COVID-19. OneJax will limit the space for attendance in UNF Hicks Hall, Meeting Rooms 1 and 2. We will be limited due to social distancing, and no more than 25 participants are permitted to congregate in the conference rooms. According to the President's Executive Proclamation, UNF enforces a mandatory mask requirement for all public buildings.*

# Sandy Miller Metrotown Institute

December 18-20, 2020

Sandy Miller  
Metrotown Institute  
Global Citizens, Different Together



4 Days that Could Change Your Life



**UNF Hicks Hall**

**4892 1<sup>st</sup> Coast Technology Parkway**

**Friday, Dec. 18<sup>th</sup>, 5:30 p.m. – 9 p.m.**

**Saturday, Dec. 19<sup>th</sup>, 9 a.m. – 9 p.m.**

**Sunday, Dec. 20<sup>th</sup>, 9 a.m. – 4 p.m.**

Metrotown Institute Application Form should be returned as soon as possible for review, but not later than **December 15, 2020**.

## **Delegate Application Form**

*Please complete each section fully and accurately.*

|  |   |                        |
|--|---|------------------------|
| First Name:  | Middle Initial:   | Last Name:             |
| The name I prefer to be called is:   |   | Date of Birth:         |
| Age:   | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other |                        |
| Student Email Address:   |   |                        |
| Parent/<br>Guardian Name:  | Parent/<br>Guardian Email:  |                        |
| To ensure diversity at Metrotown, please provide the following information <b>(optional)</b> :         |   |                        |
| Cultural/Racial Heritage:  |   | (optional)             |
| Religious/Faith Affiliation:   |   | (optional)             |
| I have participated in a OneJax event before: <input type="checkbox"/> Yes <input type="checkbox"/> No |   | If yes, which event/s? |

## **Parent/Guardian Consent**

*Please carefully read the following statement. Parent or Guardian and Delegate must sign below:*

I hereby give my consent to participate and have any pictures/images to be used for publicity and other supportive purposes. I release OneJax from any obligation or liability arising from the use of such pictures, recordings, or any other record made by OneJax.

\_\_\_\_\_  
**Name of Delegate (Print)**

\_\_\_\_\_  
**Signature of Delegate**

\_\_\_\_\_  
**Name of Parent/Guardian (Print)**

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

Metrotown supported with funding from:



**DAVID AND MONIQUE  
MILLER**

**THIS AFFECTS YOUR LEGAL RIGHTS.  
PLEASE READ CAREFULLY BEFORE SIGNING BELOW.**

DAVID AND MONIQUE  
MILLER

4. In exchange for the University allowing me to participate in the Activity, I give the University the right and permission to record my participation and appearance on videotape, audiotape, film, photography or any other medium and to use my name, likeness, voice and biographical information in connection with these recordings. The University may exhibit or distribute all or any part of these recordings for any educational or promotional purpose which the University and its employees deem appropriate. All such recordings shall be the University's property. **Initials:** \_\_\_\_\_

**5. Please pay particular attention to paragraphs 5(a) through 5(c) regarding your risk liability:**

(a) In exchange for the Activity Sponsor/Organizer/Operator making arrangements for, permitting me to and assisting me in participating in the Activity, I hereby assume all risks of participation in the Activity. Risks include, but are not limited to, transportation risks, risks of participation in the various components of the Activity, and all risks related to any physical or other condition from which I might suffer. I acknowledge that the University and/or Activity Sponsor/Organizer/Operator does **not** provide personal accident/health insurance for me, and I assume personal and financial responsibility for any medical care and treatment I may require as the result of participating in the Activity. **Initials:** \_\_\_\_\_

(b) I acknowledge and agree that sponsor/organizer/operator will not provide medical personnel at the location of the Activity. I further acknowledge and agree that the Activity Sponsor/Organizer/Operator is granted permission to authorize emergency medical treatment for me, if necessary, and that such action by the Activity Sponsor/Organizer/Operator is subject to the terms of this Release. **Initials:** \_\_\_\_\_

(c) In exchange for the University and the Activity Sponsor/Organizer/Operator allowing me to participate in the Activity and having reviewed and agreed to all acknowledgements listed in paragraphs 1 through 5(b) of this Release as detailed above, I, on behalf of myself, spouse, family, heirs, beneficiaries, and personal representatives, agree to assume all the risks and responsibilities of participating in the Activity. I release and forever discharge and covenant not to sue the University of North Florida Board of Trustees, the Florida Board of Governors, and the State of Florida, their officers, agents, employees, and representatives, including the Activity Sponsor/Organizer/Operator ("Releasees") from and against any and all liability for any and all claims, demands, actions, causes of action of whatever kind or nature, costs and expenses of any nature, including attorneys' fees ("Claims") that I may have or that may hereafter accrue to me, arising out of or related to any harm, loss, damage or injury, including but not limited to suffering, death or property loss that may be sustained by me, whether caused by my action or negligence or the action or negligence of Releasees or third parties in connection with the Activity. I also agree not to sue Releasees in connection with any such harm, loss, damage, or injury. I agree to indemnify and hold Releasees harmless from and against all claims asserted against any of the Releasees by any entity based upon my participation in the Activity. **Initials:** \_\_\_\_\_

6. I acknowledge and agree that should any provision or aspect of this Release be found to be unenforceable, all remaining provisions of this Release will remain in full force and effect. Further, I acknowledge and agree that this Release shall be construed pursuant to the laws of the State of Florida and that the venue for any legal proceeding concerning this Release shall be in Jacksonville, Duval County, Florida. **Initials:** \_\_\_\_\_

I have read, understand, and acknowledge that through initialing each of the six (6) sections above in this two page Release, that I must comply with the information and directions and intend to be bound by the terms contained in this Release and I have voluntarily executed the Release.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Participant's Signature

(I certify that I am 18 years of age or older.)

\_\_\_\_\_  
Parent or Guardian's Signature

(If Participant is under 18 years of age.)

Metrotown supported with funding from:



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# METROTOWN INSTITUTE 2020

## Medical Information Form

*This form is to be completed by parent(s) or legal guardian(s). Please complete and return to:*

*OneJax, University of North Florida  
1 UNF Drive, Building 53, Suite 2750, Jacksonville, FL 32224  
Fax: (904)620-5604*

### PERSONAL DATA *Complete in the box above requested information.*

|                          |  |                           |      |                  |                             |
|--------------------------|--|---------------------------|------|------------------|-----------------------------|
| Delegate's Last Name     |  | First Name                |      | School           |                             |
| Street Address           |  | Apt. #                    | City | State            | Zip                         |
| Home Telephone           |  | EMERGENCY CONTACT Name    |      |                  | EMERGENCY CONTACT Telephone |
| Family Physician Name    |  | Physician Phone           |      | Physician City   |                             |
| Delegate's Date of Birth |  | Medical Insurance Company |      | Policy ID Number | Insurance Telephone         |

### PAST MEDICAL HISTORY

|   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Deaf/Hearing Difficulty  | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Other<br>Please describe: |                                      |
| Allergies? (list) 1. 2. 3.  |  |                                      |
| Recent exposure to contagious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No             |  |                                      |
| <i>If so, please describe. What and when?</i>   |  |                                      |
| Does Delegate take any prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No      |  |                                      |
| <i>If so, please describe. What and when? Will this medication need to be taken during Metrotown hours?</i> |  |                                      |

### PHYSICIAN'S EXAMINATION IS RECOMMENDED

|  |  |  |
|--|--|--|
| If not possible for a physician to complete this section, parent(s) or legal guardian(s) must complete to the best of his/her ability: |  |  |
| Skin: <i>(impetigo, athletes' foot, scabies, etc.)</i>   |  |  |
| Teeth: <i>(general condition: special consideration)</i>   |  |  |
| Lungs:   |  |  |
| Heart: <i>(murmurs, rhythm, etc.)</i>  |  |  |
| Any special medical instructions including diet, limitations, etc.? <i>Please describe.</i>  |  |  |

|                                  |  |                               |      |
|----------------------------------|--|-------------------------------|------|
| Examining Physician Name (print) |  | Examining Physician Signature | Date |
| Parent/Guardian Name (print)     |  | Parent/Guardian Signature     | Date |

I have provided my Emergency Contact number above so that OneJax may notify me immediately should any emergency situation arise. In the event of an accident or medical emergency, I give my permission *(if I cannot be reached)* to the attending licensed physician to order or administer medication, anesthesia or surgical procedure as deemed necessary for the health and safety of my child *(or individual for whom I am legal guardian)*.

The medical/historical information provided above is complete and accurate to the best of my knowledge.

|                              |  |                           |      |
|------------------------------|--|---------------------------|------|
| Parent/Guardian Name (print) |  | Parent/Guardian Signature | Date |
|------------------------------|--|---------------------------|------|



## COVID-19 Screening Form for VISITORS

Delegate's Name: \_\_\_\_\_

Temperature is 100.4 degrees Fahrenheit or higher?                      Y                      N

1. Have you tested positive for COVID-19?                      Y                      N  
a. If you tested positive for COVID-19, you must provide documentation of 2 negative viral PCR test results.

2. Have you had any of the following symptoms in the last 14 days? (Please check any and all that apply.)

- a. Sore throat
- b. Cough
- c. Chills
- d. Body aches
- e. Shortness of breath
- f. Loss of smell and/or taste
- g. Fever with temperature of 100.4 or greater degrees Fahrenheit
- h. Fatigue
- i. Headache
- j. Congestion or runny nose
- k. Nausea or vomiting
- l. Diarrhea

3. Have you been in close contact with any individual who tested positive for COVID-19 in the past 14 days?                      Y                      N

4. Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?                      Y                      N

5. Have you returned from international travel or a cruise in the past 14 days?                      Y                      N

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Delegate's Signature: \_\_\_\_\_ Date: \_\_\_\_\_