



Neurons Can Fly

Summer Research Program



Dear Neurons Can Fly Scholars and Families:

Enclosed please find the various forms and information concerning your participation in the Neurons Can Fly (NCF) program.

- Residential Student Information – Pages 2-5
- Participation Agreement and Waiver Form – Page 6
- Participant Conduct Agreement- Page 7
- Medical History and Treatment Authorization –Pages 8-11
- Media, Photo, and Video Release – Page 12
- Work Activity Form- Pages 13-14 (only need to complete the “Minors Information” and Emergency Contact Information” on these two pages. Please write so all email addresses are legible.)

Please complete the following by June 20th to complete admission:

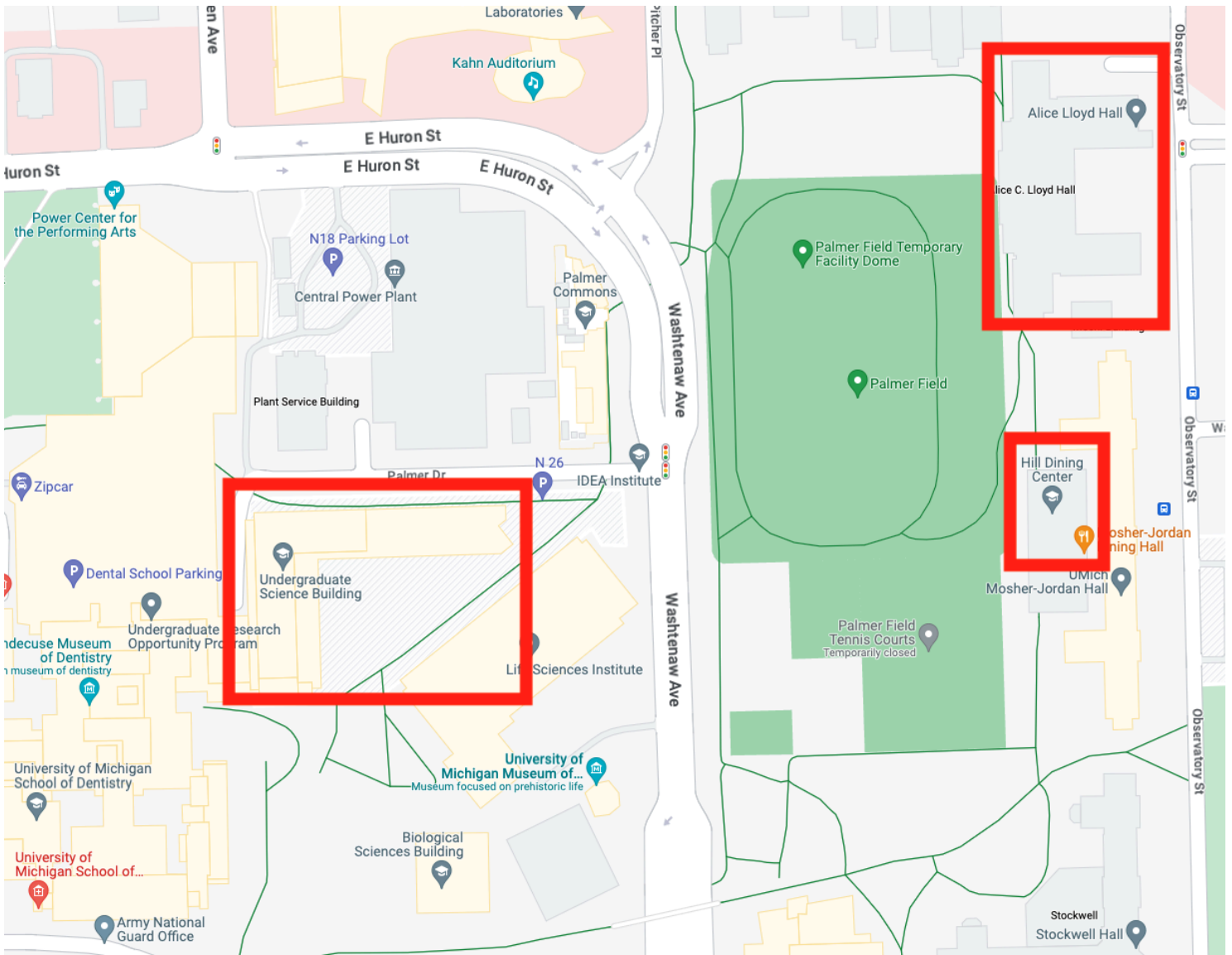
1. Complete and send a PDF copy (as one document) of all required forms (pages 6-14) to neuronscanfly@umich.edu

Residential Student Information

Residential students must arrive on campus the day before the start of their program and go directly to Alice Lloyd Residence Hall for check-in. There will be a mandatory student orientation after dinner that first night.

Sunday, July 20, 2025, arrive between 4:30 and 5:30 pm

Alice Lloyd Residence Hall
100 Observatory St, Ann Arbor, MI 48109



Residential Student Information

1. **HOUSING:** Students will reside in Alice Lloyd Residence Hall on Central Campus. <https://housing.umich.edu/residence-hall/alice-lloyd-hall/>. Students will receive a room key to enter their rooms. **PLEASE NOTE: The student will be charged a \$10.00 lost/replacement key card paid directly to the Housing office at the time of service.**
 - Participants will be housed in double rooms by gender. Male and female students will have separate areas of the building. There are gender neutral bathrooms available for student use.
 - The rooms are equipped with desks, chairs, beds, dressers, and lamps.
 - Linen package is included: XL sheet set / 1 standard pillow + pillowcase / 1 twin top sheet / 1 towel / 1 washcloth.
 - Students will not be able to enter the residence halls after 9 pm. This means they must already be inside the building prior to that time.
2. **LAUNDRY:** Coin or Pay Range app-operated laundry facilities are available in the residence hall.
3. **MESSAGES:** Messages may be left for students by calling Alice Lloyd at 734-764-1172 until 10:00 pm or emailing neuronscanfly@umich.edu. Your student will be given the message as soon as possible. In the event of an emergency after hours, students can be contacted at the residential hall by dialing the Department of Public Safety at **734-763-1131**.
4. **DINING INFORMATION:** Residential students in Hill Dining Center are provided with three meals daily: breakfast, lunch, and dinner.
 - **DIETARY RESTRICTIONS:** The dining hall will accommodate special food requests for allergies and religious beliefs. Please inform the NCF staff of specific needs. For more information regarding the dining hall, please click here: <https://dining.umich.edu/menus-locations/dining-halls/mosher-jordan/>
5. **SUPERVISION:** Male and female NCF counselors will occupy rooms in the same area as students. Counselors will supervise the residential students from 5:00 pm each afternoon through breakfast the next day. They are available throughout the night as necessary and reside in the residence hall throughout the entirety of the program. Students will be under the supervision of NCF faculty, staff, graduate/undergraduate students, or counselors at all times.
6. **VEHICLES:** Residential students are strongly discouraged from bringing vehicles to campus. NCF students will use university buses or walk during outings. If students must bring a vehicle, they are not permitted to use it during camp.

Residential Student Information

7. **TEMPORARY DEPARTURE FROM CAMPUS:** A written request will need to be on file with the administration before students will be excused from campus (i.e. doctor appointments, dinner plans, etc). Email neuronscanfly@umich.edu if you will need to pick your student up during camp week, and we will provide the required form to be filled out by the parent/guardian.
8. **SPENDING MONEY:** Students are strongly encouraged to bring an ATM, debit, or credit card.
 - Students may wish to spend money on evening outings, purchase snacks, UM memorabilia, etc. Automatic Teller Machines (ATMs) for all major and most local banks are available and they are located in several locations on central campus, including inside the Michigan Union and Michigan League.
9. **RELIGIOUS SERVICES:** Central Campus is within walking distance of houses of worship for most major religions. NCF personnel will support and assist students in attending religious services as best as possible and within reason.
10. **ARRIVAL/DEPARTURE:** Residential students should plan to arrive at the residence hall between 4:30-5:30 pm on the first Sunday of their session to check in. Students should plan to depart between 4:00 and 5:00 pm on the final Friday of their session.

What to Bring to the NCF Program

Students should prepare to pack comfortable clothing suitable for participating in lectures, laboratory, and outdoor activities. Ann Arbor, Michigan, experiences warm to hot summers with occasional cool days, so please plan accordingly. All labs require proper personal protective wear (long sleeves and pants, closed-toed shoes, hair tied back). The University buildings are often chilly.

Toiletries	Pillow (if you do not plan to use the pillow provided by UM)
Blanket	T-shirts/Sweaters/Sweatshirts
Shorts	Jeans/Pants (long pants are required for the lab)
Alarm Clock	Pajamas
Underwear and socks	Athletic Shoes/Closed-toe shoes (required for lab classes)
Small umbrella	Sandals/Shower shoes/flip-flops
Sunscreen	Light-weight jacket/raincoat
Notebook, pens, pencils	Hat/Sunglasses
Personal laptop (if possible)	Small games, decks of cards, and activities to do in the dorm
Refillable water bottle	Spending money (not required, but nice to have)
Backpack/String bag	Headphones/earbuds if you plan on listening to music in your room

Linen service **IS** provided so extra sheets are not required. The linen package includes an XL sheet set / 1 standard pillow + pillowcase / 1 twin top sheet / 1 towel / 1 washcloth.

Please note: If you require replacement linens, the student will be required to pay a \$10.00 fee payable directly to the Housing Office at the time of service. The University of Michigan is NOT responsible for any electronic devices brought from home to the NCF program, and will not replace items if they are damaged or stolen.

- Laundry facilities paid with quarters or the Pay Range app are available in the Residence Hall
- There are several small drugstores and grocery stores within walking distance. If there is anything you ‘forget’ to pack, you can purchase once you are in Ann Arbor. You may bring your favorite snack foods and drinks as well.
- There are no refrigerators in the residence hall rooms, however, some counselors will have refrigerators with limited space. **Medication that needs to be refrigerated will be accommodated first.**

If you have any additional questions, please email neuronscanfly@umich.edu



PARTICIPATION AGREEMENT AND WAIVER FORM

PROGRAM/CAMP INFORMATION

Parents and legal guardians are responsible for carefully reviewing all program materials and for selecting programs that are appropriate for their child. Information regarding University of Michigan sponsored programming for children and teens is available at childrenoncampus.umich.edu.

Program/Camp Name: _____ (hereafter "Program")

Date(s): _____ to _____

Location: _____

PARTICIPANT INFORMATION

Participant Name: _____ (hereafter "Participant")

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

PARTICIPATION AGREEMENT AND WAIVER

I understand that my child's participation in the Program is voluntary and that as a condition of my child's participation, I agree to comply with all Program requirements including, but not limited to: (a) accurately completing all registration forms in a timely manner, (b) ensuring that my child is aware of the Program's standards of conduct; (c) and immediately notifying the Program Administrator of any concerns related to the health, safety or security of my child, other participants, or Program staff.

I understand that as part of my child's participation in the Program that there are dangers, hazards and inherent risks to which my child may be exposed, including the risk of serious physical injury, temporary or permanent disability, and death, as well as economic and property loss. I further realize that participating in the Program may involve risks and dangers, both known and unknown, and I have chosen to allow my child to take part in the Program. Therefore, I, and on behalf of my child, have determined that it is reasonable to accept all risk of injury, loss of life or damage to property arising out of training, preparing, participating, and traveling to or from the Program and I do voluntarily accept and assume those risks.

I release the University of Michigan, its Board of Regents, Administration, Faculty, Staff, Graduate Students, and all other officers, directors, employees, volunteers and agents from any claims or liability arising from my child's participation in the Program, provided that such claim is not due to the gross and sole negligence of the released parties.

In the event of an accident or serious illness, I authorize representatives of the University to obtain medical treatment for my child. I hold harmless and agree to indemnify the University from any claims, causes of action, damages and/or liabilities, arising out of or resulting from said medical treatment. I further agree to accept full responsibility for any and all expenses, including medical expenses that may derive from any injuries to my Child that may occur during his/her participation in the Activity.

I also agree to indemnify the University and all of its employees and agents from any financial obligations or liabilities that my child may cause while participating in the Program, including attorney's fees and court costs resulting from his/her misconduct, errors, or omissions.

I acknowledge that University employees have undergone criminal background checks, but other participants of the event may not have undergone background check screening. As such, the University makes no assertions or assurances with respect to other participants.

This Agreement is governed by and construed under the laws of the State of Michigan without regard for principles of choice of law. Any claims, demands, or actions arising under this Agreement must be brought in the Michigan Court of Claims or a court with applicable subject matter jurisdiction sitting in the state of Michigan and I consent to the jurisdiction of a Michigan court with appropriate subject matter jurisdiction.

TRANSPORTATION AUTHORIZATION

I give permission for the University of Michigan to provide transportation of my child as a participant in the program, to and from all events under the supervision of program staff. I understand that University of Michigan leased vehicles will be used to transport my child to various extracurricular activities or in the case of emergency.

I agree that the terms and conditions of this Agreement are binding on my representatives, heirs and assigns.

Parent/Guardian Name: _____

Parent/Guardian Signature: Lisa Chang Date: _____



PARTICIPANT CONDUCT AGREEMENT

Program/Camp Name: _____ (hereafter "Program")

Date(s): _____ Time(s): _____

Participant Name: _____ (hereafter "Participant")

Parent/Guardian Name: _____

Program has established rules and standards of conduct for all Participants. It is the responsibility of the Parent/Legal Guardian and the Participant to review the Program rules and standards of conduct. Dismissed Participants are not eligible for a refund of any fees or expenses. The Parent/Legal Guardian is responsible for all costs associated with removing the Participant from the Program due to his/her misconduct, including but not limited to transportation costs to return the Participant home.

My student has my permission to accompany supervised groups of participants during program activities on campus between the hours of 9:00 am and 9:00 pm, accompanied by fellow NCF students, counselors, and/or staff only. I understand that my student is required to attend class each day, Monday through Friday. It is my understanding that my student is subject to the rules and regulations of the University of Michigan and NCF program regardless of age. I understand that any student found in possession of, or under the influence of, alcohol or non-prescribed/illegal drugs will immediately be expelled from the program. I also understand that if my student repeatedly disregards University or NCF policies and regulations, my student may be expelled from the program at the NCF Program Coordinator's discretion. I understand that if my student is sent home for any reason, all costs, fees, and charges associated with my student's return will be my responsibility and no refund will be issued.

PARTICIPANT AGREEMENT

I understand that as a condition for participating in the Program that I must comply with the Program's rules and standards of conduct and follow all reasonable direction of the Program Staff. Failure to comply with the Program's rules and standards of conduct or failure to comply with the reasonable direction of Program Staff may result in my being dismissed from the Program.

Participant's signature:

Date:

PARENT/LEGAL GUARDIAN AGREEMENT

I understand that my child will be subject to the rules and standards of conduct of the Program and the University of Michigan. I further understand that my child's violation of the rules and standards of conduct or failure to comply with the reasonable direction of Program Staff may result in my child's dismissal from the Program. I accept responsibility for all costs associated with removing my child from the Program, including but not limited to transportation costs to return the Participant home.

Parent/Legal Guardian's Signature:

Date:



MEDICAL HISTORY AND TREATMENT AUTHORIZATION

Name _____ Sex _____ Birth Date _____

Mailing Address _____ City _____ Zip _____

HEALTH HISTORY

Has the participant ever been diagnosed with asthma or exercise-induced asthma? Yes ☐ No ☐

Has the participant ever been dizzy, passed out, had chest pain, complained of being tired out more quickly than their friends, had trouble breathing or cough during or after exercise? Yes ☐ No ☐

Has the participant ever been told he/she has a heart murmur, racing heart, or skipped heartbeats? Yes ☐ No ☐

Has the participant had any injuries of any bones/joints (head, chest, shoulder, elbow, wrist, hip, knee, ankle, neck, back, etc.) or skin problems (itching, rashes, acne, etc.) during the past 12 months? Yes ☐ No ☐

Has the participant been hospitalized or had surgery during the last 12 months? Yes ☐ No ☐

Does the participant have allergies (foods, bees or other stinging insects)? Yes ☐ No ☐

Has the participant been advised by a physician during the last 12 months not to participate in physical activities? Yes ☐ No ☐

Has the participant ever been diagnosed with a seizure disorder? Yes ☐ No ☐

Has the participant had a head injury, been knocked unconscious or been diagnosed with a concussion during the last three years? Yes ☐ No ☐

Does the participant currently take any medications? If so, please list the reason, medication and dosage? Yes ☐ No ☐

Has the participant ever had a reaction to medications? If so, please list the medication and describe the reaction? Yes ☐ No ☐

Does the participant have a history of, or currently suffer from, medical conditions(s) that you or your doctor feel may limit participation or about which we need to be aware? Yes ☐ No ☐

If you answered yes to any of the above questions, please identify and explain:

PRESCRIPTION MEDICATIONS

OVER-THE-COUNTER MEDICATIONS

Select Over-the-Counter (OTC) medication may be administered if we have permission from the child/participant's parent/guardian. **Unless we have parental authorization, we will not administer ANY medications or make OTC medications available to participants unless necessary as part of general first-aid treatment.**

I give permission for the Program/Event staff to administer the following medications to my child/participant consistent with medication directions, if the need arises. Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Antihistamines (hives, swelling, allergic reaction, etc.) | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Bug Repellent | <input type="checkbox"/> Sunscreen |
| <input type="checkbox"/> Decongestants | <input type="checkbox"/> Topical ointments or powders (sunburn, anti-fungal, itch, sting, etc.) |
| <input type="checkbox"/> Eye drops for minor eye irritation | <input type="checkbox"/> Throat lozenges or spray for sore throat |
| <input type="checkbox"/> Gastrointestinal distress (upset stomach, heartburn, diarrhea, etc.) | <input type="checkbox"/> Other |

☐ Do not provide any OTC that contains the following:

EMERGENCY CONTACTS

Emergency Contact #1 Name	Home Phone #	Work Phone #	Cell Phone #	Relation
Emergency Contact #2 Name	Home Phone #	Work Phone #	Cell Phone #	Relation

AUTHORIZATION FOR MEDICAL CARE

To the best of my knowledge, my child/participant is capable of participating safely in the Program/Event and that any activity restrictions, allergies, and medications are listed on this form. As a participant, parent, or guardian I understand and acknowledge that my failure to disclose relevant information may result in harm to participant and/or others during this program/event. By signing my name I represent and warrant that I have provided all materials and important information to the University of Michigan pertaining to Participant's medical, mental and physical condition and that it is accurate and complete. I agree to notify the University of Michigan of any changes in my child's mental, physical or medical condition prior the scheduled program/event.

I give permission to Program/Event staff to provide routine first aid care and in the event of serious illness or injury, I give Program/Event staff permission to seek and authorize emergency medical treatment. I hold harmless and agree to indemnify the Program/Event and the University of Michigan from any claims, causes of action, damages and/or liabilities arising out of or resulting from said medical treatment. I further agree to accept full responsibility for any and all expenses, including medical expenses that may derive from any injuries to my child that may occur during his/her participation in this Program/event.

By revealing or disclosing the above medical information it will not be used by University personnel or employees to determine Participant's ability to participate safely in activities. I understand that, if Participant chooses to participate in activities, he/she do so voluntarily and of his/her own accord and the final decision regarding participation is solely the responsibility of myself and Participant.

Parent/Guardian Signature Lisa Chang Date _____

MEDICAL INSURANCE

The University of Michigan does not offer any form of health, liability or other types of insurance for the participant while participating in the Program/Event. If you have insurance, please provide the following information to be used only in the event that medical care for your child/participant is needed.

Company Name / Address

Policy # _____ Group # _____



SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION FORM

PROGRAM/CAMP INFORMATION

Program/Camp Name: _____ (hereafter "Program")

Location: _____ Date(s): _____

PARTICIPANT INFORMATION

Participant's Name: _____ (hereafter "Participant")

Participant's Age: _____

This form must be completed fully in order for participants to self-administer required medication. State law requires that a written emergency care plan must be on file that is "prepared by a licensed physician in collaboration with the minor child and the minor child's legal parent or guardian, and that is updated as necessary for changing circumstances." A new medication administration form must be completed for each Program attended by the participant, for each medication, each time there is a change in dosage or time of administration of a medication and/or at three month intervals. Self-medication requires licensed health care authorization and signature, and parent signature.

My child does not need to take any prescription medication while at the Program.

My child will need to take prescription medication while at the Program.

My child needs to keep this medication with him/her at all times for emergency care.

All prescription medications, including medications for conditions such as food, drug or insect allergies; diabetes; asthma; or epilepsy may be brought to the Program under the condition that the participant can self-manage care and delivery of medication with written authorization to do so by a licensed health care provider. Prescription medication must be in its original container labeled by the pharmacist or prescriber. The label must include the name, address and phone number for pharmacist or prescriber. Containers must hold only standard dose vials or the amount required for the time the participant will be attending the Program.

PRESCRIBER AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication Name: _____ Dose: _____

Condition for which medication is being administered: _____

Specific Directions (e.g., on empty stomach/with water, etc.): _____

Time/Frequency of administration: _____

_____ If as-needed, for what symptoms? _____

Relevant side effects: _____

Medication shall be administered from: _____ (date) _____ to (date) _____

Special Storage Requirements: _____

Is the participant capable of self-managed care _____ YES _____ NO

Prescriber's Name/Title: _____

Address: _____

Telephone: _____ Fax: _____ Email: _____

I hereby affirm that this individual has been instructed in the proper self-administration of the prescribed medication(s).

Prescriber's Signature: _____ Date: _____

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician or other health care provider. I indemnify and hold harmless the Program Staff, the University of Michigan, and the University's employees and agents against any claims that may arise relating to my child's self-administration of the prescribed medication(s).

Parent/Guardian Name _____

Parent/Guardian Signature: _____ Date: _____



MEDIA, PHOTO & VIDEO RELEASE FORM

Program/Camp:

Date(s):

Time(s):

Location:

Please check one box:

Yes - Media, Photo and Video Authorization

I understand that during the course of my child's participation in the above-referenced activity, that the Program, and those acting with the Program's permission or authority, may capture my child's name, likeness, image, or voice in photographic, audio, video, digital or other recording forms ("Recordings"). I give my permission for the Program to use those recordings or works produced by my child (e.g., art work) for promotional, commercial, informational, and educational purposes in any and all media (including the Internet) now existing or hereafter devised, for any purpose consistent with the Program's mission. I understand that I will not have an opportunity to review or approve uses of the Recordings or Works.

I recognize that the Program, through the Board of Regents of the University of Michigan ("University"), holds the copyright in all Recordings. I understand that neither my child nor I will receive payment or any other compensation for the taking or use of any Recordings or Works created as a result of my child's participation in the Program.

I release, indemnify and hold harmless the University from and against all liability, actions, debts, claims and demands of every kind whatsoever to the taking or use of the Recordings or Works of my child.

No-Media, Photo or Video Authorization

I do not grant permission to Program to take or use my child's name, likeness, image, or voice in any form or to use work produced by child for any reason unless necessary for the administration of the Program while my child is participating in the Program.

Participant's Name:

Parent/Legal Guardian's Name:

Parent/Guardian Signature:

Lisa Chang

Date:

Work Activity Form

Minors Performing Research Activities

Revision Date: 3/14/2023

Applies To: Supervisors/Principle Investigators, Lab Directors/Department Heads working with minors.

Minor's Information

Last Name	First Name	Middle Initial
Current Address	City/State	Zip Code
Cell Phone	Email Address	Home Phone
Date of Birth		

Emergency Contact Information

Parent/Guardian Name(s)
Parent/Guardian Primary Phone Number(s)
Parent/Guardian Email
Emergency Contact Person's Name (Other than parent/guardian)
Relationship to Volunteer
Phone Number
Email

Placement Information

Supervisor/Department Head	Department Head's Email
Department	
*Direct Supervisor (Responsible Person) Required	Supervisor's Email Address
Work Location	Phone

Description of Volunteer Duties

The hosting lab is to complete this section. Try to be as detailed as possible. Include all tasks.

Incomplete Information Example - Mary will be performing molecular experiments with yeast.

*Detailed Example - Mary will be performing protein analysis using *Saccharomyces cerevisiae* via Cell Lysis with CellLyti Y Reagent (Sigma Catalog C4482).*

Please Check the Following as Applicable to Job to be Performed

<input type="checkbox"/> Biological Materials BSL1 only (BSL2 as designated by the IBC is not allowed)	List Agent(s) and Biosafety Level:
<input type="checkbox"/> Animal Use	Complete all ACUP Requirements for Animal Handlers
<input type="checkbox"/> Radioisotope/Radiation-Producing Equipment Use	List Materials/Equipment to be Used
<input type="checkbox"/> Chemical use (Must not have a Signal Word of "Danger" ¹)	List Chemicals to be Used (or attach a list)
<input type="checkbox"/> Equipment Use	List Type of Equipment with Potential Hazard (Pipette, Centrifuge, etc.)

Appointment Dates	From	_____ (MM/DD/YY)	To	_____ (MM/DD/YY)
Schedule (If known)	Days	_____ (e.g. M-W-F)	Hours	_____ (e.g. 9 am—5 pm)

¹<https://www.osha.gov/sites/default/files/publications/OSHA3492QuickCardLabel.pdf>