MEDICINE CONNECT

Parent / Guardian Consent and Optional Publicity Authorization

For applicants under age 18 • Medicine Connect Sunrise Scholarship 2026–2027

Student

Student Name: _____ Date of Birth: _____

Part A — Required Parent / Guardian Consent

I am the parent or legal guardian of the student named above. I authorize the student to participate in the Medicine Connect Sunrise Scholarship program and, if selected, to accept the scholarship award. I understand that Medicine Connect may verify application information and administer the program under its Official Rules.

Parent / Guardian Name: _____

Signature: _____ Date: _____

Email / Phone: _____

Part B — Optional Publication / Publicity Authorization

This section is optional. Declining publicity authorization will not affect scholarship eligibility or scoring.

Please select:

☐ YES, I authorize Medicine Connect to publicly identify the student as a participant or scholarship recipient and to use the student's name in reasonable program-related announcements.

☐ YES, I authorize reasonable program-related use of the student's photograph and/or submitted personal story, subject to Medicine Connect's normal editorial practices.

☐ NO, I do not authorize public use of the student's name, photograph, or personal story beyond what is legally or administratively necessary.

Parent / Guardian Signature: _____ Date: _____