

Medical Release Form
Emmanuel College Dance Competition
January 25, 2009

Liability Release: For good and valuable consideration, the receipt and sufficiency of which hereby acknowledged, I _____, am parent or legal guardian of _____, a minor (hereinafter "Participant"). I hereby grant the permission necessary to allow the Participant to participate in the 2009 Emmanuel College Dance Competition (hereinafter "Releasee"). I, in my own behalf of the Participant, further agree to release and hold harmless Emmanuel College and all affiliated with the Releasee including directors, officers, representatives, members, agents, athletic trainers, and employees (hereinafter "Releasees") from any and all liability, including negligence, and any claim judgment, loss, liability, costs and expenses (including without limitations, court or attorney's fees) arising or connected with the Releasee, including traveling to and from the site of the competition. I further expressly agree to indemnify and hold harmless the Releasee and Releasees, the heirs, successors, assigns, executors, and administrators against loss from any further claims, demands, or actions that may be subsequently brought by Participant or by any other persons on the account of any damages of any character resulting to Participant in any way from the forgoing activities.

I understand that one qualified certified trainer will be in attendance at the tournament, and further agree to allow the certified athletic trainer to treat Participant of any and all injury(s) or illness(s) incurred prior to, during, and at the conclusion of the competition. I further agree that if, in the judgment of the athletic training staff, further treatment for any condition required, the Participant () may () may not be transported to Children's Hospital. If treatment other than Children's Hospital is desired, please specify preferred medical treatment center below.

Signature of Legal Guardian or Legal Aged Participant _____

Date _____

Address _____

City _____ State _____ Zip Code _____

Telephone (____) _____

Health Insurance Provider _____ Policy # _____

Preferred Medical Center _____