

LIABILITY WAIVER AND MEDICAL RELEASE

Parent/Guardian Signature Date
Student Signature (parent or guardian must also sign if student under 18 years old) Date
have read this entire Release. I fully understand it and I agree to be legally bound by it.
understand and acknowledge that my participation in this activity is not covered under the assurance of Baldwin Wallace University.
recognize that this Release means I am giving up, among other things, rights to sue the University, as employees, faculty, coaches, and agents for injuries, damages, or losses I may incur. I also understand that this Release binds my heirs, executors, administrators, and assigns, as well as myself.
Further, I grant all coaches or responsible faculty or staff affiliated with Baldwin Wallace University, and /or, in their absence, other responsible adults present and acting on their behalf, permission to act the area of obtaining medical treatment. I also assume financial responsibility for any medical reatment for myself, or my child. I certify and understand the contents of this consent form and my ignature represents my consent on my behalf or, in the case of a minor, on behalf of the minor.
agree to assume all of the risks and responsibilities in any way associated with this activity. In onsideration of and return for the services, facilities, and other assistance provided to me by the University in this activity, I release, indemnify and hold harmless Baldwin Wallace University, its imployees, faculty, community partner organizations, and agents, from any and all liability, claims, and actions that may arise from injury or harm to me, from my death, or from damage to my property in connection with this activity. I understand that this Waiver and Release covers liability, claims, and actions caused entirely or in part by any acts, or failure to act of the University, its employees, aculty, community partner organizations, and agents, including but not limited to negligence, mistake, or a failure to supervise.
fully recognize that there are dangers and risks to which I may be exposed by participating in the activity during the following dates: These risks include, but are not limited to: catastrophic injury, paralysis, emotional distress, strains, sprains, cuts, or uises, broken bones, and other injuries up to and including death. I am in good health and know of no medical reason why I should not participate in this activity.
acknowledge that I make this waiver on a voluntary basis, that there may be risk to myself and I coluntarily assume that risk. This assumption is made freely and knowingly without any coercion rom anyone.
will be participating in the following activity:
Name

13524410.1 February 2013

BALDWIN WALLACE UNIVERSITY



Emergency Medical Release Form The following information is necessary to provide appropriate medical service, if required.

	NAME					
Student Information:	(Last)	(Fir	rst)	(Middle)		
illiormation.	Date of Birth/	/ Gender	_ Age School			
	Parent/Guardian Home					
			eZip			
	Phone					
Personal Medical	Alcohol/Drug Abuse	Hay Fever	Emotional Problems	Seizures		
History:	Asthma Diabetes	Heart Disease Hepatitis	Emotional Problems Migraine Headache Pneumonia	Thyroid Trouble Tuberculosis		
	Eating Disorders	High Blood Pressure Kidney Disease	Rheumatic Fever	Ulcers		
	Please list any surgeries y					
	Please list any surgeries your child has had Tetanus Shot (List month and year of last shot) List any other pertinent medical information					
		edicai information				
Disabilities:	My child needs accommod	dation for the following physica	l limitation(s) and/or handicap(s	s):		
		allergies? Yes No				
Allergies:	Specify any dietary issues	ː				
	Is your child taking any medications or currently receiving other medical treatment? Yes No					
Medications:						
	Mother's or Gua	rdian's Information	Father's of Guardian's Infor	mation		
In Case of	Name	Name				
Emergency:	Home Telephone	Home	Telephone			
	Work Telephone	Work 1	Telephone			
	Place of work	Place o	of Work			
			event that parents or guardians			
		Pho rmission to pick your child up?				
	2003 tills person nave per	miliodion to pick your crillia up?	163 NO	,		
Family Physician:	Doctor's Name		Phone			
	Address					

ACCEPTANCE OF HEALTH SERVICE EMERGENCY TREATMENT					
arises, including permission for my child	PERMISSION for my child to receive all neces d to be transported to and seen and/or treated rmined solely at the discretion of the emergence	by the nearest hospital in the			
SIGNATURE OF PARENT/GUARDIAN	RELATIONSHIP TO CHILD	DATE			
PARTICIPANT MUST HAVE MEDICAL INSURANCE					
	Name of Insurance Company				
Group Number	Policy Number	er			
Name of Policy Holder/Relationship to Participant					
PHOTO RELEASE					
I authorize Baldwin Wallace University to use photographs of my child and his/her work for promotional purposes which may include Baldwin Wallace University online and print publications or submission to the press for use in articles or advertisements.					
☐ Yes ☐ No					
Parent/Guardian Signature		Date			