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2010 Activity Participation/Emergency Medical Authorization Form

Dear Parents or Guardians,

In order for your child to participate in the above activities, our insurance company requires this form to be on file for every child. Please take a minute and check all of the above activities in which your child participates. Fill out the remaining portion of this form and return it to your child's class next week.

Student's name _____ Date of Birth _____

Home Address _____ City/State _____ Zip _____

Name of emergency contact _____ Relation to child _____

Emergency phone # _____ Home phone # _____ Cell phone# _____

Is sponsor, Akron Baptist Temple, authorized to approve medical treatment? yes no

Is participant covered by personal/family medical insurance? yes no

If yes, name of insurer _____ policy or group # _____

Participation Agreement

By signing below, the parent/guardian acknowledges and accepts the risks of physical injury associated with participation in the activities check above. Except for gross negligence on the part of the sponsor, the parent/guardian accepts personal financial responsibility for any bodily or personal injury sustained during the activities. Further, the parent/guardian promises to hold harmless the sponsoring organization and its representatives for any injury related to the activities.

If a dispute over this agreement or any claim for damages arises, the parent/guardian agrees to resolve the matter through a mutually acceptable arbitration process.

Signature _____ Date _____
(Parent/guardian of minor)

Emergency Medical Agreement

In the event that I cannot be reached at _____ (phone #) or other parent _____ at _____ (phone #), I consent to the administration of any treatment deemed necessary by Dr. _____

(preferred physician) or Dr. _____ (preferred dentist). In the event that the above designated preferred medical practitioner is not available, I consent to the administration of any treatment deemed necessary by another licensed physician or

dentist. In the event that it is deemed necessary to transfer the child, my preferred hospital is _____; although

it may be necessary to transfer the child to another reasonable, accessible facility.

Note: This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concur in the necessity of such surgery.

Signature _____ Date _____

Address _____ City/State _____ Zip _____

Please list facts concerning the child's medical history, including allergies, medication being taken or any physical impairments to which a physician should be alerted.

