STUDENT PERSONAL LIABILITY AND MEDICAL RELEASE FORM

I hereby agree to release Advantage Academy of Hillsborough, Inc. dba Bell Creek Academy , its representatives, agents and employees from liability for any injury to the named person or caused by the named person, resulting from any cause whatsoever including but not limited to any negligence, gross negligence or willful misconduct occurring to or by the named person at any time while participating in the Executive Internship Program, including travel during the hours of the Program.

I do voluntarily authorize the Executive Internship Program and designee to administer and obtain routine or emergency procedures and treatment for the named person as deemed necessary in medical judgment.

I agree to indemnify and hold harmless the Advantage Academy of Hillsborough, Inc. dba Bell Creek Academy, its representatives, agents and employees for any and all claims, demands, actions, right of action and/or judgments by or on behalf of the named person arising from or on account of said procedures and or treatment rendered in good faith and according to accepted medical practices.

I fully understand that this is an educational activity and will, to the best of my ability, apply myself for the purpose of learning and will uphold at all times the finest qualities of a person representing the Executive Internship Program.

Student: _____ Date: _____

Parent/Guardian: _____ Date: _____

Teacher/Coordinator: _____ Date: _____

Employer: _____ Date: _____

NOTE: All persons under legal age must have a parent or guardian sign this form. If you are age 18 or older please indicate and provide a copy of proof. Otherwise this form will not be accepted. All participants and parents/guardians must complete the Student Personal Liability and Medical Release form and sign this form. Parental/Guardian signatures indicate permission for their child to participate in the program if selected.

STUDENT PERSONAL LIABILITY AND MEDICAL RELEASE

After you have read the liability and medical release section and completed its conditions, please fill out and sign below.

Name: _____ Birth Date: _____

Age: _____

Family Physician: _____ Phone Number: _____

Father's Name: _____ Phone Number: _____

Father's Address: _____

Mother's Name: _____ Phone Number: _____

Mother's Address: _____

Person to Contact In Case of Emergency: _____

Phone Number: _____

Address: _____

Name of person responsible for your medical bills (guarantor) _____

Phone Number: _____

Guarantor relationship to you: _____

Insurance Company: _____Plan Number _____

Group Number: _____Insured _____

Do you have any known allergies? □ Yes □ No If yes, please list the details.

_____

Do you have any history of heart condition, diabetes, asthma, epilepsy, or any other existing medical conditions?
Explain here: _____