Siena Heights University Creative Stages at Siena Heights University
Waiver and Medical Release Form – Winter 2019

Dear Parents or Guardians,
Thank you for your interest in the Siena Heights University Creative Stages at Siena Heights University! We are committed to offering your child high quality instruction along with a safe environment.

I understand and agree that Creative Stages at Siena Heights University (the "Activity"), coordinated by Siena Heights University (the "University"), a nonprofit Michigan corporation, involves certain risks and that regardless of the precautions taken by the University, some bodily injuries may occur. This Release covers any and all events and occurrences associated with the Activity, including my child's participation and observation. If I have any concerns about my child's health or ability to participate, I agree to discuss my concerns with their physician before deciding they can participate.

I understand and agree that the University cannot control all of the risks associated with this type of activity, but may need to respond to accidents and potential emergencies that involve my child. Therefore, I hereby give my consent to the provision of emergency medical treatment to the extent that the treatment is necessary in the medical opinion of the medical professional rendering the treatment.

I agree to assume the risk that unexpected events may occur and result in harm, injury, death, or illness to my child, or damage to or loss of my child's property while I am participating in or observing the Activity. I agree to indemnify the University for any harm or damage associated with my child's participation or observation if the harm or damage is not due to the negligence or fault of the University. I understand that my child's participation is voluntary.

I have read and understand this Release and have voluntarily signed it with a full understanding of its purpose and consequences. I represent that I am eighteen (18) years of age or older and that I am otherwise competent to execute this Release on behalf of the listed minor age child. I grant to Siena Heights University, its representatives and employees the right to take photographs or video of my child and my child's property in connection with the above-identified activity. I authorize Siena Heights University, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

My signature of this Release hereby releases, indemnifies, acquits, and forever discharges the University, its officers, employees, trustees, and agents of and from any and all liability, damage, injury or claims of any kind and nature whatsoever, at law or in equity, and the consequences thereof, which may accrue, in any way arising out of, related to or in connection with the Activity.

Participants Name _____

Signature of parent/legal guardian _____ Date _____

Print name of parent/legal guardian _____

Relationship to participant _____

In case of Emergency Contact: _____

At the following number(s)_____

If the Emergency Contact Person I have listed is not available, please contact:

Doctor: _____ Phone: _____

Who may the listed participant be released to (print name and cell phone number):

_____
_____ (OVER)

Emergency or Medical Treatment of Minor

In the event of an emergency or for medical treatment, I hereby give my consent and authorize the University Health Service or the closet Hospital Emergency Department to provide medical services for my minor daughter/son/ward. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required, and is to serve as specific consent to any and all such diagnoses, treatment or hospital care, which may be deemed desirable.

REQUIRED HEALTH HISTORY

Medication minor is now taking: _____

Minor's allergies to drugs, medicines, plants, food: _____ Has the minor ever had: (Answer Yes or No)

___Rheumatic Fever
___Heart Disease
___Asthma
___Hay Fever
___Anemia
___Bladder, Kidney Infection
___Tuberculosis
___Hepatitis
___Persistent Migraine Headaches
___Pelvic Infection

List any other pervious illness, injury or surgery_____

List any chronic illnesses or physical limitations (use of wheelchair or walker)

_____ Identify approximate dates of minor's immunizations:

_____Tetanus _____Measles

INSURANCE INFORMATION

_____ ___
Name of Insurance Company

_____
I.D. or Contract Number

_____
Policy Holder's Name

_____
Service Code or Insurance Number

(_____)_____
Policy Holder's Phone Number

_____
Group Numbers or Policy Numbers

_____
Policy Holder's Address State Zip

_____
Relationship to Minor

PARENT/GUARDIAN INFORMATION

I request that payment under my medical insurance program be made directly to the site of services rendered. I understand that I am financially responsible for fees not covered by this authorization.

_____
Name of Parent/Guardian

_____
Address

_____
Signature of Parent/Guardian

_____
City State Zip

(_____)_____
Home Phone

(_____)_____
Work Phone

_____
Date

Please list any special services you may require due to an existing medical condition or physical disabilities