CONSENT FORM, RELEASE FROM LIABILITY & INDEMNITY AGREEMENT

I/We, the undersigned parent(s) or guardian(s) of_____, a minor, do hereby CONSENT to his/her participation in the _____ Internship Program (hereafter referred to as the "Program") for the weeks of ___ _____, 20_____. I/We RELEASE and discharge the _____, and its departments, officers, employees, and agents (hereinafter collectively referred to as "Releasees"), from any and all claims, damages, losses or expenses of whatever kind or nature which I/we may have or acquire as the parent(s) or guardian(s) of said minor arising out of or resulting, directly or indirectly, from said minor's participation in the Program.

I/We also RELEASE and discharge _____ from any and all claims, damages, losses or expenses of whatever kind or nature which said minor may have or acquire arising out of or resulting from, directly or indirectly, his/her participation in the Program.

I/We furthermore agree to defend and INDEMNIFY ____ against any claim, damage, loss or expense of whatever kind or nature that _____may have to pay that arises from said minor's intentional, grossly negligent, or reckless acts or omissions while participating in the Program.

I/We hereby authorize _____ employee(s) or agent(s) who is supervising said minor to act on our behalf in authorizing and consenting to emergency medical care for said minor if he/she becomes ill or is injured while participating in the Intern program. This Authorization and Consent may be presented to the appropriate emergency medical staff at such time as emergency medical care is required.

I/We hereby RELEASE and discharge_____from any and all claims of any nature whatsoever, which may arise out of the decision to provide emergency medical care.

_____

Signature of Parent or Guardian/Date/Nature of Relationship

_____

Signature of Parent or Guardian/Date/Nature of Relationship

MEDICAL INFORMATION FORM

Student's Name _____

Parent/Guardian's Name _____

Home Address _____

Home Phone_____Cell Phone_____Work Phone _____

Medical Insurance Provider: _____

Medical Insurance Policy: _____

Policy #: _____

Primary Subscriber of Medical/Health Policy: _____

Name of Student's Health Care Provider_____Phone # _____

If parent/guardian not available in emergency, please notify:

Name_____Name _____

Phone_____Phone _____

Address_____Address _____

Relationship_____Relationship_____

Health History

Please list any and all chronic or recurring illnesses:

_____
_____
_____
_____

Please list any and all medication that your child takes on a regular basis:

_____
_____
_____

Please list any and all allergies, or drug sensitivity and instructions pertaining to their administration:

_____
_____
_____