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

Able Trust 10-2013
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:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________