

Johnson University

PERMISSION TO PARTICIPATE AND PARENTAL CONSENT FORM

*Please Print Legibly:*

**Participant Information**

Full Name of Child/Participant (First/Middle Last) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Grade in School \_\_\_\_\_ School \_\_\_\_\_

Home Phone #: (     ) \_\_\_\_\_ Alternate Phone #: (     ) \_\_\_\_\_

Health Issues/Allergies/Activity Restrictions/Medications \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Required Emergency Medical Information**

Health Insurance (    ) Yes (    ) No    Company \_\_\_\_\_ Policy # \_\_\_\_\_

Primary Insured \_\_\_\_\_

Family Physician \_\_\_\_\_ Office Phone # \_\_\_\_\_

**Parent Information**

Name of Parent(s) /Legal Guardian: \_\_\_\_\_

\_\_\_\_\_

Address (if other than Participant) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # (     ) \_\_\_\_\_ Alternate Phone # (     ) \_\_\_\_\_

Email Address \_\_\_\_\_

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**PERMISSION FOR PARTICIPATION IN CAMPUS EVENT ACTIVITIES, RELEASE OF LIABILITY**

I, the undersigned, certify that I am the parent or legal guardian of the above mentioned Participant. I hereby authorize my minor child named above to attend and participate in the Campus Event Activities (CEA) of Johnson University (Johnson), including any off-campus CEA for which I have registered him/her. I understand that my minor child must obey all established rules and follow the instructions of the person in charge of the CEA. I consent to and understand that the person in charge of the CEA or agents have the right to dismiss my child who is in their opinion a hazard to the safety and well-being of others, I understand that if my child is sent home under such circumstances I will be responsible for all associated costs incurred, including the cost of special travel arrangements.

Prior to the participation of my minor child, I acknowledge that there are certain risks associated with certain Campus Event Activities, including, by way of example, physical injury due to activity-related accidents, and physical injury due to transportation-related accidents, illness or even death. Furthermore, In addition, I acknowledge that there may be other risks inherent in these activities of which I may not be presently aware. Accordingly, I acknowledge that participation in such activities involves certain dangers and risks which may expose my child to hazards of bodily injury or property damage, and which may result in my child being unable to contact me or be unable to receive immediate medical care and assistance if injury occurs.

By signing this parental consent and liability form, I expressly warrant that my child named above is capable of withstanding both the physical and mental demands associated with any CEA for which s/he is registered. I also expressly assume all risks to my child's participation in these CEA, whether such risks are known or unknown to me at this time. In recognition of these risks and realities, and in consideration of my child being offered the opportunity to participate in and benefit from Campus Event Activities, I agree on behalf of myself and my child to release, waive, and disclaim any and all liabilities of or claims against, Johnson University, its officers, board members, agents, faculty, employees, and all private persons or organizations Volunteering services without charge to transport, supervise, or chaperone my child while participating in such Campus Event Activities including, but not limited to any or all liabilities or claims for personal injury, property damage, court costs, attorneys' fees and interest, however, caused or accrued, as a result of my child participating in the Johnson - sponsored event.

**MEDIA RELEASE**

I hereby give Johnson University and their legal representatives and assigns, the right and permission to photograph, digitally record, videotape, or audio tape, my above named child while s/he is attending participating in any Campus Events occurring on or off the Johnson University campus. I further agree that any or all of the material recorded may be used, in any form, in publications, including electronic publications, or in audio-visual presentations, promotional literature, advertising, or in other similar ways, and that such use shall be without payment of fees, royalties, special credit, or other compensation. I understand that all such recordings, in whatever medium, shall remain the property of Johnson University.

**MEDICAL AUTHORIZATION / CONSENT FOR MEDICAL TREATMENT OF A MINOR**

I recognize that there may be occasions where the minor child named above, may be in need of first aid or emergency medical or dental treatment as a result of an accident, illness, or other health condition or injury. Therefore, I authorize any Johnson University Staff Member, or Adult Volunteer, in whose care the minor child has been entrusted, to consent to any X-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the provisions of the Medical Practice Act by the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. In so doing, I agree to pay all fees and costs arising from this action to obtain medical treatment.

As parent or legal guardian of my minor child (Participant named above), I am responsible for the health care decisions of my minor child and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay for dental, medical, and/or hospital care or treatment to be rendered to my minor child is legally sufficient and that no consent from any other person is required.

By signing below I authorize any Johnson University Staff Member or Adult Volunteer, in whose care the minor child has been entrusted to authorize any hospital or physician or other health care provider to bill the following insurance company or companies for the payment of any services rendered to the minor child. I agree to assume responsibility for the charges for such care as rendered to the above named minor child.

I authorize any hospital, physician, or other health care provider to release information from the minor child's medical record to the insurance company named below, in connection with the completion of any insurance claim form.

**I have read, understood and agreed to the information above. All releases, authorizations and permission granted above shall remain in effect unless revoked in writing by the undersigned to Johnson University Florida, 1011 Bill Beck Blvd, Kissimmee, FL 34744.**

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date