Arete Classical

Participant's Name_____ Birthdate_____
Street Address _____City _____ Zip_____
EMERGENCY INFORMATION
Father's Name_____ Home Phone (_____)_____ Cell/Bus Phone (_____)_____
Mother's Name _____ Home Phone (_____)_____ Cell/Bus Phone (_____)_____
In an emergency when parent/guardian cannot be reached or is not applicable, please contact the following:
Name_____ Home Phone (_____)_____ Cell/Bus Phone (_____)_____
Name_____ Home Phone (_____)_____ Cell/Bus Phone (_____)_____
Allergies_____
Other Medical Conditions_____
Physician_____ Cell Phone (_____)_____ Bus Phone (_____)_____
Medical/Hospital Insurance Company_____ Phone (_____)_____
Policy Holder's Name_____ Policy Number_____

THIS AUTHORIZATION FOR EMERGENCY MEDICALTREATMENT MUST BE COMPLETED BEFORE STUDENT CAN PARTICIPATE IN ARETE CLASSICAL CO-OP. TREATMENT FOR ILLNESS OR INJURY WILL BE BASED ON INFORMATION PROVIDED HEREIN.

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the supervisors (tutors, parents, and adult volunteers) of Arete Classical Co-op, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under said supervision), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an adult volunteer and specifically consent to such practices, and

I agree to indemnify and hold harmless all agents, volunteers, tutors, and parents involved in Arete Classical Co-op, as well as the owners of the property on which Arete Classical Co-op conducts activities, against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Parents/Guardians Signature_____ Date_____
(Parents/Guardians' Signature is required if participant is under the age of 18)

Student's Signature_____ Date_____
(Student's Signature is required)

NOTE: ATTACH COPY OF YOUR INSURANCE CARD, FRONT AND BACK, TO EXPEDITE MEDICAL TREATMENT.