CERTIPORT
Achieve • Distinguish • Advance

MEDICAL AND LIABILITY RELEASE

I give my permission for _____, to participate in Certiport's Competition. Although Certiport desires to provide a safe and enjoyable time for all students, accidents can still happen. I/we understand that there are risks involved with participation. In consideration of myself/my child being allowed to participate in this event, I/we agree to assume responsibility for those ordinary and reasonable risks associated with the activities. I/we agree to hold harmless Certiport, its affiliated organizations, employees, agents, and representatives from any and all claims arising from my/my child's participation. This release agreement does not apply to claims of intentional (criminal) misconduct or gross negligence by Certiport, its employees, or volunteers. If such circumstances are proved in a court of law, I/we acknowledge and agree that Certiport can assume no financial liability beyond its actual liability insurance policy in force.

In case of accident, illness, or other emergency, I/we request that Certiport contact me. If Certiport cannot reach a parent/guardian after conscientious effort, I/we give permission for Certiport staff to call paramedics or attempt to contact a listed physician or dentist first. If a life-threatening emergency exists, I/we give permission for Certiport staff to call paramedics immediately and then contact me/us as soon as possible thereafter.

I/we authorize and consent to any X-ray examination, anesthetic, medical, dental, or surgical treatment, and hospital care which, in the best judgment of a licensed physician or dentist, is deemed advisable. I/we agree to assume the financial responsibility for expenses incurred as a result of those services being provided. I/we also agree to be financially responsible for emergency medical transportation.

STUDENT NAME (Printed): _____ **DOB** _____ **GENDER** _____

IN CASE OF EMERGENCY, PHONE# WHERE YOU CAN BE REACHED: _____

ALTERNATE NUMBER: _____

HEALTH CARE PROVIDER INFORMATION (IF APPLICABLE): _____

PHYSICIAN: _____ **PHONE:** _____

DENTIST: _____ **PHONE:** _____

HEALTH INSURANCE CARRIER: _____

INSURED'S NAME: _____ **FAX NUMBER:** _____

RELATIONSHIP: _____

ALLERGIES (INCLUDING REACTIONS TO MEDICATIONS): _____

_____

ARE THERE ANY PHYSICAL OR MEDICAL CONDITIONS WE SHOULD KNOW ABOUT NOT ALREADY STATED? _____

_____

_____

_____

_____

PARENT/GUARDIAN'S SIGNATURE: _____ **DATE:** _____

WITNESSED BY: _____ **DATE:** _____

If you have any questions, please call Terry at **801-847-3135**.
Please fax to **801-772-3299**, email to *jallen@certiport.com* or mail to
1275 South 820 East, Suite 200, American Fork, Utah 84003. Please return no later than July 15th, 2005.