Daily Medical Assistance, First Aid, and Emergency Medical Treatment

I,_____, recognize there may be occasions where I may require assistance completing certain parent- or guardian-authorized daily medical activities, medical first aid, or emergency medical treatment as a result of accident, illness, or other health condition or injury.

I (or my parent or guardian) do hereby give permission to Madonna School and Community Based Services ("MSCBS"), including its agents and employees, to assist the above-named participant with any authorized daily medical activities, or to seek and secure any needed medical attention or treatment for the above-named participant, including hospitalization, if, in MSCBS' opinion, such need arises. In doing so, I (or my parent or guardian) agree to pay all fees and costs arising from the medical treatment. I (or my parent or guardian) give permission for attending physician(s) and other medical personnel to administer any needed medical treatment, including surgery. I (or my parent or guardian) also agree to allow the hospital or medical agent to release the above-named participant back to MSCBS' staff after treatment.

Release of Liability

I (or my parent or guardian) hereby release MSCBS, including its agents and employees, and agree to hold them harmless from any and all liability, claims, damages, actions and causes of action whatsoever, for loss, damages or injury to persons or property relating to the authorized daily medical activities and/or medical treatment described above.

I (or my parent or guardian) further agree to disclose in writing below, all physical and medical conditions, limitations, and sensitivities of the above-named participant. I (or my parent or guardian) represent that I (or my parent or guardian) am physically and medically able to understand the risks involved in such authorized daily medical activity and that I (or my parent or guardian) expressly assume such risk.

_____ _____

PARTICIPANT SIGNATURE DATE

_____ _____

PARENT OR LEGAL GUARDIAN DATE

MEDICAL HISTORY

Include special medical needs or concerns, such as asthma, allergies, conditions, dietary needs, medications, etc. Please list all conditions, limitations or sensitivities of participant. Also, please list any conditions for which you have seen a physician in the past year and other information that should be known about the above-named participant:

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