EMERGENCY MEDICAL AUTHORIZATION LIABILITY WAIVER AND RELEASE OF CLAIMS & MEDICAL INFORMATION FORM

LAST NAME: _____

FIRST NAME(S): _____

(Please print) _____

_____

Complete one form for all family members with the same insurance. _____

Use a separate form for those with other insurance. _____

*** CONFIDENTIAL ***

EMERGENCY MEDICAL AUTHORIZATION (WAIVER)

In consideration of being selected to participate in the production of Tetélestai, I, the undersigned, intending to be legally bound for myself, my minor dependents and heirs, executors and administrators; waiver and release Cleveland Performing Arts Ministries (CPAM) and Knight Sound & Lighting (KSL), their members, volunteers and sponsors from any and all claims for personal injuries, losses and damages I, or my minor dependents, may suffer or sustain by my or their participation in Tetélestai.

I understand that CPAM and KSL do not provide any medical insurance or care for its participants and that strobe lights and high levels of sound are used in the production of Tetélestai.

I understand that in the event of a medical emergency, reasonable attempts will be made to reach the parent/guardian of minors. If this fails, I hereby give my permission for representatives of CPAM to seek emergency medical treatment for any and all persons listed.

LIABILITY WAIVER AND RELEASE OF CLAIMS:

I acknowledge that I derive personal satisfaction and a benefit by virtue of my voluntarism with CPAM, and I willingly engage in CPAM activities and performances (the "Activity").

RELEASE AND WAIVER.

I HEREBY RELEASE, WAIVE AND FOREVER DISCHARGE ANY AND ALL LIABILITY, CLAIMS, AND DEMANDS OF WHATEVER KIND OR NATURE AGAINST THE CLEVELAND PERFORMING ARTS MINISTRIES AND ITS AFFILIATED PARTNERS AND SPONSORS, INCLUDING IN EACH CASE, WITHOUT LIMITATION, THEIR DIRECTORS, OFFICERS, VOLUNTEERS, AND AGENTS (THE "RELEASED PARTIES"), EITHER IN LAW OR IN EQUITY, TO THE FULLEST EXTENT PERMISSIBLE BY LAW, INCLUDING BUT NOT LIMITED TO DAMAGES OR LOSSES CAUSED BY THE NEGLIGENCE, FAULT OR CONDUCT OF ANY KIND ON THE PART OF THE RELEASED PARTIES, INCLUDING BUT NOT LIMITED TO DEATH, BODILY INJURY, ILLNESS, ECONOMIC LOSS OR OUT OF POCKET EXPENSES, OR LOSS OR DAMAGE TO PROPERTY, WHICH I, MY HEIRS, ASSIGNEES, NEXT OF KIN AND/OR LEGALLY APPOINTED OR DESIGNATED REPRESENTATIVES, MAY HAVE OR WHICH MAY HEREINAFTER ACCRUE ON MY BEHALF, WHICH ARISE OR MAY HEREAFTER ARISE FROM MY PARTICIPATION WITH THE ACTIVITY.

MEDICAL ACKNOWLEDGMENT AND RELEASE. I acknowledge the health risks associated with the Activity, including but not limited to transient dizziness, lightheaded, fainting, nausea, muscle cramping, musculoskeletal injury, joint pains, sprains and strains, heart attack, stroke, or sudden death. I agree that if I experience any of these or any other symptoms during the Activity, I will discontinue my participation immediately and seek appropriate medical attention. I DO HEREBY RELEASE AND FOREVER DISCHARGE THE RELEASED PARTIES FROM ANY CLAIM WHATSOEVER WHICH ARISES OR MAY HEREAFTER ARISE ON ACCOUNT OF ANY FIRST AID, TREATMENT, OR SERVICE RENDERED IN CONNECTION WITH MY PARTICIPATION IN THE ACTIVITY.

As a participant/volunteer you recognize that your participation, involvement and/or attendance at any Cleveland Performing Arts Ministries, Inc practice, program or activity ("Activity") is voluntary and may result in personal injury (including death) and/or property damage. By attending, observing or participating in the Activity, You acknowledge and assume all risks and dangers associated with your participation and/or attendance at the Activity, and You agree that: (a) the Cleveland Performing Arts Ministries, Inc (b) the property or site owner of the Activity, and (c) all past, present and future affiliates, successors, assigns, employees, volunteers, vendors, partners, directors, and officers, of such entities (subsections (a) through (c), collectively, the "Released Parties"), will not be responsible for any personal injury (including death), property damage, or other loss suffered as a result of your participation in, attendance at, and/or observation of the Activity, regardless if any such injuries or losses are caused by the negligence of any of the Released Parties (collectively, the "Released Claims"). BY ATTENDING AND/OR PARTICIPATING IN THE ACTIVITY, YOU ARE DEEMED TO HAVE GIVEN A FULL RELEASE OF LIABILITY TO THE RELEASED PARTIES TO THE FULLEST EXTENT PERMITTED BY LAW.

MEDICAL INSURANCE INFORMATION *(This information MUST apply to all listed above)*

Name of **Insured *** _____ Insurance Company _____

Place of Employment _____ Policy #, Class or Group _____

CONTACT INFORMATION

*** Insured's:**

Home Phone _____

Cell Phone _____

Work Phone _____

Emergency Contact:

Name _____

Relationship _____

Home Phone / Cell Phone _____

INDIVIDUAL MEDICAL INFORMATION **** * MUST be completed and signed for EACH person listed above.***

*The information provided below will be used to provide assistance to medical personnel for your treatment in a medical emergency. It is **CONFIDENTIAL** and will be viewed ONLY by CPAM officers, Tetelestai Executive Director, KSL staff or appropriate medical personnel.*

Doctor's Name: _____ First & Last Name: _____

Doctor's Phone #: _____ Date of Birth: _____

Medical Conditions / Chronic Illnesses: _____

Current Medications (include dosage): _____

Allergic to these medications: _____

Special Emergency Instructions: _____

Signature of Adult or Parent/Guardian:	**Date:**

ADDITIONAL FAMILY MEMBERS ON BACK

INDIVIDUAL MEDICAL INFORMATION - CONTINUED **** * MUST be completed and signed for EACH person listed above.***

The information provided below will be used to provide assistance to medical personnel for your treatment in a medical emergency. It is ***CONFIDENTIAL*** *and will be viewed ONLY by CPAM officers, Tetelestai Executive Director, KSL staff or appropriate medical personnel.*

Doctor's Name: ______________________ First & Last Name: ______________________

Doctor's Phone #: ______________________ Date of Birth: ______________________

Medical Conditions / Chronic Illnesses: ______________________

Current Medications (include dosage): ______________________

Allergic to these medications: ______________________

Special Emergency Instructions: ______________________

Signature of Adult or Parent/Guardian:	**Date:**

Doctor's Name: ______________________ First & Last Name: ______________________

Doctor's Phone #: ______________________ Date of Birth: ______________________

Medical Conditions / Chronic Illnesses: ______________________

Current Medications (include dosage): ______________________

Allergic to these medications: ______________________

Special Emergency Instructions: ______________________

Signature of Adult or Parent/Guardian:	**Date:**

Doctor's Name: ______________________ First & Last Name: ______________________

Doctor's Phone #: ______________________ Date of Birth: ______________________

Medical Conditions / Chronic Illnesses: ______________________

Current Medications (include dosage): ______________________

Allergic to these medications: ______________________

Special Emergency Instructions: ______________________

Signature of Adult or Parent/Guardian:	**Date:**