EMERGENCY MEDICAL RELEASE AND LIABILITY WAIVER

(Please Print)

PARTICIPANT INFORMATION					
Last name:		First:		Middle:	Birth Date:
Street address:			Email Address:	Daytime Phone ( )	
City	State		Zip:	Evening Phone ( )	

IN CASE OF EMERGENCY			
Name of person to contact in emergency:	Relationship to participant:	Daytime Phone ( )	Evening 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________________________________

In case of medical emergency, due to illness or injury the undersigned authorizes Paul Smith's College to secure and retain medical treatment and transportation if needed.

This authorization includes x-ray, surgery, hospitalization, medication, anesthetic, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) above is unable to be

THIS AUTHORIZATION FOR EMERGENCY MEDICALTREATMENT MUST BE COMPLETED BEFORE PARTICIPANT CAN ATTEND.

I the undersigned participant or parent/guardian of the above participant (if under the age of 18) understand that the activities involved in this program have certain risks, and I acknowledge for myself, my heirs, executors or assigns, that I understand such risks. I understand that provision has been made for protective equipment and the avoidance of risk. Nevertheless I release and forever discharge Paul Smith's College, its trustees, officers and employees from any and every liability, claim or damage of any kind, nature or description.

I further hereby agree to hold Paul Smith's College harmless, and I assume any and all risk of every kind and nature sustained by me (or participant by reason of my personal choice to engage in this activity with a full understanding that I willingly assume any and all damage, detriment, hurt or impairment, for any cause directly connected with these activities and experiences.

Parents/Guardians Signature____ Date______________________

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

Participant's Signature____ Date______________________

(Participant's Signature is required)

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

Return this form before July 5 to the attention of
Mary L. McLean, Paul Smith's College, PO Box 265, Paul Smiths, NY 12970-0265
or by fax (518) 327-6267 or email mmclean@paulsmiths.edu