Macomb Community College
Education • Enrichment • Economic Development
Discover. Connect. Advance.℠

Release of Liability/Photo Release

Name of Program: _____

Name of Participant: _____
(print or type)

RELEASE OF LIABILITY: In consideration of Participant being permitted to participate in the Macomb Community College Program(s) named above, Participant's Parent or Guardian, hereby release, discharge and covenant not to sue Macomb Community College, its trustees, officers, agents and employees from all liability for any and all claims, damages, costs or causes of action I/we have or may participating in the above Program(s).

☐ ***Child is not to be photographed***.

PHOTO RELEASE: I give my consent for my child to be photographed or videotaped for promotional purposes. I do not expect compensation when Macomb takes promotional photos and videos of students in the learning environment.

GOVERNING LAW: This waiver and release shall be governed by and construed in accordance with the laws of the State of Michigan. The participant or participant's parent/guardian acknowledges, by his/her signature below, that (s)he has read this document and release, that (s)he understands its terms and conditions, and that (s)he agrees to be bound by its terms and conditions as an express condition of participation in the event.

By signing this Release, I certify that I have read the above *Release of Liability/Photo Release* statement and understand their terms.

_____ _____
Date: Participant's Parent/Legal Guardian Signature

Emergency Medical Information

Macomb Community College

Workforce & Continuing Education

Parents or Legal Guardians, please complete the following, and email to:

Camp Scrubs—*healthcareers@macomb.edu*

Career Academies—K-12relations@macomb.edu

Prior to the first day of camp

STUDENT'S NAME | GRADE | DATE OF BIRTH

STUDENT'S ADDRESS | CITY/STATE | ZIP CODE | PHONE NUMBER

PARENT/LEGAL GUARDIAN | RELATIONSHIP | PHONE DURING CLASS

ADDRESS IF DIFFERENT FROM STUDENT

CHILD'S DR | ADDRESS | PHONE NUMBER

DR.'S HOSPITAL AFFILIATION | ADDRESS | PHONE NUMBER

MEDICAL INFORMATION: ☐ NONE ☐ CONVULSIVE DISORDERS ☐ DIABETES ☐ ALLERGIES* (I.E. DIET, STINGS) ☐ OTHER _____

**If checked, please clip at corner perforation*

DESCRIBE SYMPTOMS AND PRECAUTIONS

OTHER PERTINENT MEDICAL INFORMATION

REQUIRED SIGNATURE | PLEASE PRINT NAME | DATE

PHONE (CELL/HOME) | PHONE (WORK)