



Academic Ventures, LLC

1802 Lakeview Ave.

Rocky River, OH 44116

Parent/Guardian Permission and Consent to Medical Treatment
(Please sign BOTH forms on this page.)

(Name of Student) _____ has my permission to participate in the following campus tour arranged by Academic Ventures, LLC via a commercially chartered motor coach operator.

DESTINATION CAMPUS _____

DATE _____ TIME OF DEPARTURE _____ ANTICIPATED TIME OF RETURN _____

I understand the nature of the activity in which my son/daughter will be participating and that he/she is expected to behave in a mature, responsible manner abiding by the same code of conduct mandated by his/her School's rules and regulations while participating in this activity.

I understand that I / _____,
(NAME OF GUARDIAN TRAVELING WITH STUDENT ON TOUR)

is liable or responsible for the conduct or safety of my son/daughter while he/she is participating in this activity.

I hereby give my permission for son/daughter to participate in the above-described activity.

I further agree that, in the event of an accident, illness or any other circumstance requiring medical treatment, such treatment may be procured for my son/daughter without financial obligation or legal liability on behalf of Academic Ventures, LLC.

Date: _____ Signature of Parent/Guardian _____

IMPORTANT MEDICAL INFORMATION THE SUPERVISOR SHOULD KNOW: _____

EMERGENCY TELEPHONE NUMBERS: _____
(Please complete the form below)

AUTHORIZATION TO TREAT A MINOR

I (We), the undersigned parent, parents or legal guardian of _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of Ohio. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Date: _____ Signature of _____
Father and/or Mother, or Guardian

Allergies to Drugs or Foods _____

Date of last Tetanus Toxoid Booster _____

440-356-8743

440-356-8753 (fax)

academicventures.com