Part One: Required

RELEASE, HOLD HARMLESS, AND INDEMNIFICATION AGREEMENT

Program Information

Program Name: UT High School Arts Academy
Date: _____
Location: Art + Architecture Building
1715 Volunteer Blvd. Knoxville, TN 37996

Participant Information

Participant Name: _____
Address:_____
City, State, Zip Code:_____
Date of Birth: _____

I am the parent or legal guardian of the Participant named above ("Participant"), who is under eighteen (18) years of age. I am fully competent to sign this Release, Hold Harmless, and Indemnification Agreement ("Agreement"). In consideration for Participant being allowed to participate in the Program identified above ("Program"), the receipt and sufficiency of which I hereby acknowledge, I agree as follows:

1. I acknowledge, understand, and accept that as part of Participant's participation in the Program there are dangers, hazards, and inherent risks to which Participant may be exposed, including but not limited to the risks of serious physical injury, temporary or permanent disability, death, and economic and property loss. I know of no reason why Participant should not participate in the Program.

2. I, individually, and on behalf of Participant and our respective heirs, successors, assigns, and personal representatives, hereby forever release, acquit, discharge, covenant not to sue, and agree to indemnify and hold harmless for any and all purposes The University of Tennessee and its trustees, officers, employees, agents, and volunteers in official and individual capacities ("Releasees") from any and all liability whatsoever for any and all damages, losses, or injuries (including but not limited to death) to persons or property or both, including but not limited to any and all claims, demands, actions, cause of actions, damages, losses, injuries, costs, expenses, and attorney's fees, that result from, arise out of, or are related to:
    a. Participant's participation in the Program, Participant's travel to or from the Program, or Participant's presence on premises owned, leased, or operated by Releasees, *INCLUDING BUT NOT LIMITED TO DAMAGES, LOSSES, OR INJURIES SUSTAINED AS A RESULT OF THE NEGLIGENCE OF RELEASEES*;
    b. the administration of prescription or over-the-counter medication to Participant, and/or the failure to administer prescription or over-the-counter medication to Participant, *INCLUDING BUT NOT LIMITED TO DAMAGES, LOSSES, OR INJURIES SUSTAINED AS A RESULT OF THE NEGLIGENCE OF RELEASEES*; or
    c. medical treatment of Participant, any decision whether to seek medical treatment for Participant, and/or traveling to or from a medical care facility, *INCLUDING BUT NOT LIMITED TO DAMAGES, LOSSES, OR INJURIES SUSTAINED AS A RESULT OF THE NEGLIGENCE OF RELEASEES*, even if a Releasee has signed medical documentation promising to pay for the treatment due to my inability to sign the documentation.
3. I, individually, and on behalf of Participant and our respective heirs, successors, assigns, and personal representatives, hereby agree to indemnify and hold harmless the Releasees for any and all damages, losses, or injuries (including but not limited to death) to persons or property or both, including but not limited to any and all claims, demands, actions, cause of actions, damages, losses, injuries, costs, expenses, and attorney's fees, that result from, arise out of, or are related to Participant's negligent or intentional act(s) or omission(s) during Participant's participation in the Program, Participant's travel to or from the Program, or Participant's presence on premises owned, leased, or operated by Releasees.

4. I agree that this Agreement shall be governed by the laws of the State of Tennessee. I agree that this Agreement is intended to be as broad and inclusive as permitted by the laws of the State of Tennessee, and if any provision of this Agreement is held invalid, I agree that the remaining provisions shall, notwithstanding, continue in full legal force and effect.

5. In signing this Agreement, I acknowledge and represent that I have read and understand it and sign it voluntarily, and no oral representations, statements, or inducements apart from the foregoing Agreement that has been reduced to writing have been made.

Signature of Participant's Parent or Legal Guardian: _____

Printed Name of Participant's Parent or Legal Guardian: _____

Date: _____

Part Two: Required

MEDICAL INFORMATION AND MEDICAL TREATMENT RELEASE AND AUTHORIZATION FORM

Program Information

Program Name: UT High School Art Academy
Date: _____
Location: Art and Architecture Building

Participant Information

Participant Name: _____
Address:_____
City, State, Zip Code:_____
Date of Birth: _____

Medical Information

The decision whether to permit the participant identified above ("Participant") to participate in the program identified above ("Program") is the sole responsibility of Participant, his/her parent(s) or legal guardian(s), and/or his/her physician(s). The following information will not be used by The University of Tennessee to determine Participant's ability to participate safely in the Program.

Participant's Primary Care Physician's Name and
Phone#:_____
Date of Participant's most recent tetanus toxoid immunization:_____

For the following questions, please circle a response and explain as appropriate:

Does participant have any limiting medical conditions that Participant, you, and/or Participant's doctor believe may limit Program participation? If "yes," please identify the condition and explain its limiting effect: (use the back of this form or a separate sheet if necessary)	YES NO
Is Participant currently taking any medication that Participant, you, and/or Participant's doctor believe may interfere with his/her ability to participate safely or effectively in the Program? If "yes," please identify the medication and explain its potential effect: (use the back of this form or a separate sheet if necessary)	YES NO
Does Participant have a history of allergies or reactions to medications, insect stings, plants, or foods? If "yes," please explain the history: (use the back of this form or a separate sheet if necessary)	YES NO
Does Participant have a history of, or currently suffer from, any other medical condition(s) of which the Program staff needs to be aware? If "yes," please identify the medical condition(s) and explain what the Program staff needs to know: (use the back of this form or a separate sheet if necessary)	YES NO

Part Three: Required

MEDICAL INFORMATION AND MEDICAL TREATMENT RELEASE AND AUTHORIZATION FORM (PAGE 2)

Medical Insurance Information

Policy holder's name: _____
Policy holder's relationship to Participant: _____
Policy holder's address: _____
Please either attach a photocopy of both sides of your insurance card (preferred) or provide the information requested here:
Insurance company name and address: _____
Insurance company phone number: _____
Policy numbers: _____

Emergency Contact Information

Name of Participant's Emergency Contact: _____
Daytime telephone number: _____
Evening telephone number: _____
Relationship to Participant: _____

Authorization for Medical Treatment

In the event of an accident or serious injury or illness, I hereby authorize The University of Tennessee and its trustees, officers, employees, agents, and volunteers in official and individual capacities ("Releasees") to obtain medical treatment for Participant. I further agree to accept full responsibility for any and all expenses, including but not limited to medical expenses, that result from, arise out of, or are related to any injuries to my Child that may occur during his/her participation in the Program, Participant's travel to or from the Program, or Participant's presence on premises owned, leased, or operated by Releasees, *INCLUDING BUT NOT LIMITED TO INJURIES SUSTAINED AS A RESULT OF THE NEGLIGENCE OF RELEASEES*.

As Participant's parent or legal guardian, I understand and acknowledge that my failure to disclose relevant information may result in harm to Participant and/or others during this Program. By signing my name I represent and warrant that I have provided all material information to The University of Tennessee pertaining to the medical condition(s) identified above and that it is accurate and complete. I agree to notify The University of Tennessee in writing of any changes in the medical condition of the Participant prior to the start of the Program.

I understand that my disclosure of the medical information above will not be used by The University of Tennessee to determine Participant's ability to participate safely in the Program. I understand that, if Participant participates in the Program, he/she does so voluntarily and of his/her own accord and the final decision regarding participation is solely the responsibility of Participant, me, and/or his/her physician(s).

Signature of Participant's Parent or Legal Guardian :_____

Printed Name of Participant's Parent or Legal Guardian:_____

Date: _____

Part Four: If Applicable
AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Program Information

Program Name: UT High School Art Academy
Date: _____
Location: Art and Arch Building

Participant Information

Participant Name: _____
Address:_____
City, State, Zip Code:_____
Date of Birth: _____

This form must be completed fully in order for the participant identified above ("Participant") to self-administer prescription medication during the program identified above ("Program"). A separate form must be completed for each medication to be administered. Self-administration of medication requires the written authorizations (below) of a licensed health care professional and Participant's parent or legal guardian.

_____ **No, my child does not need to take any prescription medication during the Program.**
_____ **Yes, my child will need to take a prescription medication during the Program.**

All prescription medications, including medications for conditions such as food, drug, or insect allergies; diabetes; asthma; or epilepsy may be brought to the Program under the condition that Participant can self-manage care and delivery of medication. Prescription medication must be in its original container labeled with the minor's name, medication name, dosage, and time/frequency of administration.

AUTHORIZATION FROM PRESCRIBER FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication name: _____
Dosages:
_____
Condition(s) for which medication is being administered:
_____
Specific directions (e.g., on empty stomach, with water):
_____
Time/frequency of administration:
_____
If PRN, frequency: _____
If PRN, for what symptom(s): _____
Relevant side effect(s):
_____
Medication shall be administered from _____ to _____
Special storage requirements: _____
Is Participant capable of self-managed care:

I hereby affirm that Participant has been instructed in the proper self-administration of the above-described medication.
Prescriber's name: _____
Prescriber's signature: _____
Date: _____

I hereby authorize and recommend Participant to self-administer the above-described medication. I also affirm that Participant has been instructed in the proper self-administration of the above-described medication by his/her physician.

Signature of Participant's Parent or Legal Guardian: _____

Printed Name of Participant's Parent or Legal Guardian:_____

Date: _____

Part Five: If Applicable
AUTHORIZATION FOR DISPENSATION OF OVER-THE-COUNTER MEDICATION

Program Information

Program Name: UT High School Art Academy
Date: _____
Location: Art and Arch Building

Participant Information

Participant Name: _____
Address:_____
City, State, Zip Code:_____
Date of Birth: _____

Over-the-counter medication ("OTC medication") may at times need to be dispensed to a participant in the above-described program if approved by the participant's parent or legal guardian. Please complete this form to save time if you choose to authorize Program staff to offer OTC mediation to the participant described above ("Participant") during the Program. **NOTE: The University of Tennessee will not dispense any OTC medication without the written authorization of a participant's parent or legal guardian.**

I authorize Program staff to offer the following medications to Participant if the need arises, in the sole judgment of the staff of the Program, as directed on the manufacturer's container (check the blanks below for each OTC medication(s) you authorize):

_____ Ointments for minor wound care, first aid as directed (e.g., antiseptic, anti-itch, anti-sting, antibiotic, sunburn)
_____ Tylenol/Acetaminophen
_____ Ibuprofen
_____ Throat lozenges and/or spray for a sore throat
_____ Micatin or other anti-fungus treatment for athlete's foot
_____ Kaopectate or Imodium for diarrhea
_____ Milk of Magnesia, Pepto Bismol, or Mylanta for upset stomach or nausea
_____ Rolaids or Tums for acid reflux, heartburn, or indigestion
_____ Benadryl for swelling, hives, or allergic reaction
_____ Actifed or Sudafed for nasal congestion or allergy relief
_____ Visine or other eye drops for minor eye irritation
_____ Medicated lip ointment for dry, chapped lips, lip blisters, or canker sores
_____ Swimmer's ear drops
_____ Hydrocortisone ointment for mild skin irritations, poison ivy, or insect bites
_____ Medicated powder for skin irritation
_____ Robitussin or other cough syrup
_____ Calamine lotion for bug bites and poison ivy
_____ Sunscreen
_____ Insect repellant
_____ Other (list any other approved OTC medications):

Program staff reserves the right to use generic equivalents when available for the name brand OTC medications identified above.

If Participant is allergic to any type of OTC medication, please identify the OTC medication(s):
_____

Program staff will contact Participant's emergency contact if Participant has any condition associated with fever.

I hereby authorize the dispensation of OTC medications to Participant as indicated above. I understand that such dispensation will not be done under the supervision of medical personnel. I understand that the OTC medications indicated above are not necessarily kept on hand and may not be available to be dispensed immediately.

Signature of Participant's Parent or Legal Guardian:_____

Printed Name of Participant's Parent or Legal Guardian: _____

Date: _____