Authorization for Medical Treatment for Minors
The University of Texas at Arlington
Educational Talent Search Program

Name of Student ____________________________            Current Grade Level __________________________

I (we) ______________________________________ and ________________________________________
( Parent Name)                                ( Parent Name)

__________________________________________________________
City     State    Zip     Phone Number

am the parent or legal guardian of the above named minor who is referred to in this agreement as my dependent.

I understand that participation in this program involves varying risk of injury or bodily impairment. In
consideration of UTA permitting my dependent to participate in this program, my dependent and I hereby
voluntarily assume all reasonable risks associated with participation and agree to discharge and release the State
of Texas, the Regents of The University of Texas at Arlington, their agents, servants and employees, from any
and all liability, claims, causes of action of demands of any kind and nature whatsoever which may arise by or in
connection with my dependent’s participation in any activities related to this program. I understand this
assumption of risk, discharge and release does not apply in situations when loss or damage is due to the sole
negligence of the University, its agents, servants or employees. The terms of the agreement shall serve as a
release, discharge and assumption of risk for my heirs, estate, executor, administrator, assignees and all
members of my family.

My dependents and I recognize the importance of adhering to all program regulations and following instructions
regarding program activities, such as swimming, sports, field trips and other strenuous activities. My dependent
and I agree to abide by such regulations and instructions.

My dependent is in good health and I know of no medical reason why he/she is not able to participate in this
program.

I hereby consent to first aid, emergency medical care and, if necessary, admission to an accredited hospital when
necessary for treatment for injuries that my dependent may sustain while participating in this program.

I understand that it is my obligation to have a health and accident insurance policy in effect that covers my
dependent, and that I am responsible for any and all medical expenses, which may be incurred as a result of
accident or illness while participating in the program. I understand that activity insurance provided through the
program provides only limited protection, on an excess basis, for injuries which occur while participating in
program activities and may not cover medical expense due to illness or the entire medical expense of any injury.

__________________________ _________________________ ______________________
Signature of Parent/Guardian     Date        Number to call in case of emergency

My insurance company is: __________________________________________________________
Policy #: _____________________________ Effective Date of Coverage: _______________

Additional Emergency Contact: _______________________________________     ___________________
Name               Relationship
__________________________ _________________________ ______________________
Phone    Cell Phone   Work/Additional Phone

PLEASE PRINT CLEARLY AND RETURN TO OUR OFFICE AS SOON AS POSSIBLE.
STUDENT WILL NOT BE ALLOWED TO ATTEND ANY TRIP/ACTIVITY WITHOUT
THIS FORM ON FILE. THANK YOU.