

AGREEMENT RELEASE FORM

IN THE EVENT OF MEDICAL EMERGENCY

For medical and accident insurance, I will be insured under:

POLICY NUMBER: _____

NAME OF INSURANCE COMPANY _____

DATE OF EXPIRATION (if any) _____

In addition, I hereby assume responsibility for all medical expenses I may incur while participating in the program.

MEDICAL AUTHORIZATION: In the event that (I) (we) cannot be reached to give (my) (our) consent, (I) (we) the undersigned parent or guardian of: _____

hereby authorize Cornell University's representative to consent for (me) (us) to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care deemed necessary or advisable by a licensed physician during the period of my participation.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of Cornell University to give specific consent to the diagnosis, treatment or hospital care which is deemed advisable in the best judgment of a licensed physician.

(If applicable) I certify that I am the parent or legal guardian of the person named above, that I have read the preceding agreement and that I join the agreements without reservation, granting my consent to all actions provided for herein.

PARENT / GUARDIAN SIGNATURE _____

PRINT NAME ABOVE _____

ADDRESS _____ **HOME TELEPHONE** _____

Please list person to be notified in the event of a medical emergency:

Name _____ Relationship to student: _____

Daytime phone number: _____

Evening phone number: _____

Cellular: _____

Email: _____

Please complete and return this form to:

**CORNELL IN ROME, 149 EAST SIBLEY HALL, CORNELL UNIVERSITY,
ITHACA, NEW YORK 14853**