EXHIBIT C

MEDICAL INFORMATION

The undersigned hereby authorize the University to secure emergency medical treatment for the Participant. The space below contains any allergies, required medications, special medical conditions, medical insurance information, and any other pertinent medical information regarding the Participant.

Allergies: _____

Medications: _____

Special Conditions: _____

Name of Insurance Carrier: _____
Policy Number: _____
Other: _____

In the event of an emergency, please contact the following person:

Name: _____
Daytime Phone Number: _____
Evening Phone Number: _____

The undersigned acknowledge and agree that the University shall have no obligation to contact the above-referenced person in the case of an emergency, but that the University will make reasonable efforts to contact this person in the event of an emergency.

The undersigned certify that the foregoing medical information is correct, and that this consent and information is being voluntarily provided to the University.

_____
Parent/Guardian Signature

_____
Parent/Guardian Signature