MEDICAL AUTHORIZATION

PARENTAL/GUARDIAN CONSENT & AUTHORIZATION

I, the undersigned, am the parent or legal guardian of ________________________________, a minor child, younger than 18 years of age, ("My Child"), whose address is ____. I acknowledge that My Child has been provided with the opportunity to participate in the Team Ropes Adventure Challenge ("TRAC") and all activities related thereto (the "CUSTOMER's Program") occurring on ____, which shall take place at the following location: 3000 N.E. 151st Street, North Miami, Florida 33181 on The Florida International University Board of Trustees' ("FIU") Biscayne Bay Campus, in Miami, Florida. I understand and agree that FIU's sole role in this matter is to allow ____ (the "CUSTOMER") to use the TRAC for CUSTOMER'S Program as further described and outlined in the accompanying Ropes Course Agreement between FIU and CUSTOMER.

We/I, the parent(s) or guardian(s) of My Child, do hereby request that FIU, through its agents or employees, take whatever steps necessary to secure medical treatment for My Child in the event My Child appears to be, at the sole discretion of FIU, in need of such treatment while attending CUSTOMER'S Program. We/I consent to the rendering of all necessary treatment, including, but not limited to, admission to a hospital or other appropriate health care facility, in such institutions and at such places as FIU, in its sole discretion, acting through its agents or employees, deems best. I authorize the agents or employees of FIU to execute whatever forms and/or actions might be necessary to ensure complete and adequate care of My Child and guarantee payment of all charges incurred as a result of any medical treatment or emergency transportation deemed necessary.

If this document is being signed by only one parent, I, the undersigned, affirm that I have been judicially granted sole custody of the participant. If this document is being signed by a guardian(s), I/we, the undersigned, affirm that I/we have been judicially granted legal guardianship of the participant.

In signing this Medical Authorization, we/I acknowledge and represent (i) that we/I have read and understand it; (ii) that we/I sign it voluntarily and for full and adequate consideration, fully intending to be bound by the same; and (iii) that we/I are at least eighteen (18) years of age and fully competent. We/I understand that this is a legal document which is binding on us/me, our/my heirs, executors, administrators, and assigns and on those who may claim by or through us/me.

_______________________________________ _______________________________________

Parent or Guardian (please print) Parent or Guardian Signature Date

____ ____

Parent or Guardian (please print) Parent or Guardian Signature Date

____

Home, Work and Mobile Phone Number(s) of Parent(s) or Guardian(s)

____

Address Parent or Guardian

____ ____

Medical Insurance Company Name Policy Number/Plan Number