



Register for Summit Experientia on-line via the Summer Program link on The Summit CDS website (credit card or e-check accepted) or by sending the registration forms and 100% of the class fee (checks only) to Linda Didday in the business office. If not currently a registered student at The Summit, the agreement and emergency medical forms must be submitted to complete registration. There is a registration fee of \$25/ class. Class size is limited. The payment will be returned only if the class has the maximum number of students already registered or if the program is cancelled by The Summit. Confirmation will be emailed to this email address:

\_\_\_\_\_ .

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Student's Name	Mr. /Mrs. /Ms./Dr. Parent's Name (if applicable)	Street Address	Home Phone	Emergency Phone
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City, State, Zip Code	School Currently Attending (if applicable)	School Attending Next Year	Principal's Name	Current Grade
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Course No.	Course Name	Date of First Day of Class	Amount
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Registration Fee	25.00
Total	_____

If sending in registration please make check payable to The Summit Country Day School and mail to: The Summit Country Day School — Business Office (attn: Linda Didday), 2161 Grandin Road, Cincinnati, Ohio 45208-3300 (513.871.4700, ext. 850).

# AGREEMENT TO PARTICIPATE, WAIVER AND INDEMNIFICATION

I/We undersigned, parent(s)/guardian(s) of \_\_\_\_\_, a minor under age of twenty-one (21), do hereby grant permission for said minor to participate in the Summer School class(es) \_\_\_\_\_ provided by The Summit Country Day School.

Print Name of Minor

Print Name of Class(es)

In consideration of the above name minor being allowed to participate in The Summit Country Day School Summer Class

\_\_\_\_\_, the undersigned, on behalf of the named minor, and on behalf of

Print Name of Class(es)

the minor's parent(s), heirs, executors and administrators, voluntarily assume all risk of accident, injury, or damage and release and forever discharge The Summit Country Day School, and its respective employees, officers, agents and the community of The Summit Country Day School, from any and all liability for personal injury or property damage of any kind sustained in association with or during participation in the program, regardless of whether such personal injury or property damage is caused by the negligence of The Summit Country Day School.

The undersigned agree to indemnify and hold harmless The Summit Country Day School and its respective employees, officer and agents, as well as the community of The Summit Country Day School, from all liability, loss and expense, including, but not limited to damages, legal expenses and cost of defense, in any matter arising during or from the participation in Summit Experientia.

The undersigned further agree that said minor will abide by all applicable rules and regulations promulgated by Summit Experientia.

\_\_\_\_\_  
Signature of Participant and Date

\_\_\_\_\_  
Signature of Parent/Guardian and Date

\_\_\_\_\_  
Print Name of Participant

\_\_\_\_\_  
Print Name of Parent/Guardian

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority and parents or guardians who cannot be reached

Student's Name Street Address School/Grade Date of Birth Phone

Part I or II must be completed:

PART I - GRANT CONSENT

In the event reasonable attempts to contact me at Home Mother's Work/Cell Father's Work/Cell

have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by

Dr. Name and Phone Number of Preferred Physician or Dr. Name and Phone Number of Preferred Dentist or in the event

the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to

or any hospital reasonably accessible.

Preferred Hospital

Note: This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child s medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted:

Signature of Parent/Guardian and Date

PART I - REFUSAL TO CONSENT (Do not complete if you completed Part I)

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

Signature of Parent/Guardian and Date