

**BETHEL COLLEGE PILOT CHEERLEADING  
MEDICAL TREATMENT AUTHORIZATION AND LIABILITY RELEASE**

I, \_\_\_\_\_, do hereby grant permission for myself to participate in the activity of cheerleading at Bethel College. In order that I may receive the necessary medical treatment in the event I may sustain injury or illness during participation in this activity, I hereby authorize the cheerleading coach or other supervising adult to obtain medical treatment for myself for such an injury or illness during the activity, and I hereby hold Bethel College and its representatives harmless in the exercise of authority.

I understand that this activity involves risk to me, the participant. I further acknowledge and understand that due to the nature of this activity, which involves inversion and rotation of the body, there is a possibility that I may sustain physical illness or injury (minimal, serious, or catastrophic), in connection with my participation, and I further release Bethel College and its representatives from any claims for personal illness or injury that I may sustain during participation in this activity.

I further understand that Bethel College has established rules and regulations pertaining to conduct, behavior, and activities of all students and cheerleading participants, by which I must abide during participation in this activity, and that I will be responsible for my failure to abide by those rules and regulations.

I have read and understood the above Medical Treatment Authorization and Liability Release.

\_\_\_\_\_  
**Signature of Parent or Guardian (if Participant is Under 18)      Date**

\_\_\_\_\_  
**Participant's Signature      Date**

**Parent(s) Name(s):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_

**Member Name:** \_\_\_\_\_ **Subscriber Name:** \_\_\_\_\_

**Identification #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Insurance Company's Phone Number:** \_\_\_\_\_

**Claim Address:** \_\_\_\_\_

\_\_\_\_\_  
**Member's Date of Birth:** \_\_\_\_\_