

WAIVER AND RELEASE
Permission Form for Minors



Activity: M-Power Life Skills Program Date of Activity: _____

Minor's Name: _____ Parent's Cell Phone: _____

Minor's Address: _____

I, _____, the parent or legal guardian of the above-named minor, hereby give my permission for his/her participation in the youth Activity named above. I have directed my child to cooperate and conform to directions and instructions of persons responsible for the activities).

In signing this form, I warrant and represent that I am the parent or legal guardian, that I am 18 years of age or older; and I indemnify and hold harmless, release and discharge Help One Child and its constituent organizations, officers, agents, employees, and volunteers from any and all claims for personal injuries, property damage or wrongful death that my child may suffer as a result of his/her participation in the activity described above, whether or not such injuries or damages are caused by the negligence (active or passive) of any of the entities or individuals named or described above.

I agree that in the event my child is injured as a result of his/her participation in the above-named activities, including transportation to and from these activities, recourse for the payment of any hospital, medical, dental, or related costs and expenses will be paid either by me or my spouse, accident, hospital or medical insurance, or any available benefit plan of mine or my spouse.

I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician, surgeon, or dentist licensed under the Medical Practice Act and Dental Practice Act. As parent or legal guardian, I am responsible for the health care decisions of my child and am authorized to consent to services to be rendered, and no other consent is required by law.

I hereby give permission to the physician selected by the Activity supervisory personnel then present to render medical treatment deemed necessary and appropriate by the physician or dentist.

(Delete or edit accordingly) I, hereby, authorize the making of photographs, motion pictures, videotapes, recordings, or other memorializing of said event and his/her participation therein, and the publication or other use thereof and waive any right to compensation therefore or any right that he/she otherwise might have to limit or control such.

Parent or Legal Guardian Signature

Date

Print Name of Parent or Legal Guardian

Relationship

Daytime Phone

Night Phone

Cell Phone

Contact Person (other than above)

Relationship

Daytime Phone

Night Phone

Cell Phone

Name & Phone of Primary Physician

Health Policy Number

Food and/or Medicine Allergies

