AFTER SCHOOL PROGRAM PARTICIPANTS RELEASE

The undersigned does hereby waive, release and forever discharge any and all claims against the St. Mary of Hannah Parish and School its commissioners, employees, volunteers or agents for damages and/or injuries to the undersigned which may arise from the participation in the

St. Mary of Hannah Parish and School After School Events and Athletic Programs.

SPORT INVOLVED: After School Board Games for Gr. K-8 on Thursday, February 17 and March 3 and 17, 2022 from 3-4:00 pm. **Students will complete any missing assignments before participating**.

PARTICIPANT'S GRADE: \_\_\_\_\_\_\_\_\_AGE: \_\_\_\_\_\_\_\_\_\_\_BIRTHDATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARTICIPANTS NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As you probably already know, a minor may not be treated even in an emergency situation except when, in the opinion of the attending physician, a life is in the balance. Written consent is required for all treatment given in any hospital emergency room/center. Consent of a parent or legal guardian is necessary for unmarried minors, women under 18 and men under 21 except in cases of extreme emergency. Grandparents, neighbors, sisters, brothers CANNOT authorize treatment.

To whom it may concern: As a parent/guardian, I do hereby authorize the treatment by a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

NAME OF MINOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP TO YOU: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Season for when release is intended: February 17 and March 3 and 17, 2022

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent or Guardian)

ADDRESS OF MINOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY PHYSICIAN: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES, REACTIONS OR OTHER COMMENTS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Revised: Sept. 2019