MEMORIAL DAY SCHOOL

PERMISSION & MEDICAL RELEASE FORM

ATHLETE'S LAST NAME: _____, FIRST NAME: _____ MI: _____

ASSUMPTION OF RISK

I am aware playing or practicing to play / participate in any sport or sport related activity could be a dangerous activity involving **MANY RISKS OF INJURY.** I understand that the dangers and risks of playing or practicing to play / participate in sports or sport related activity include, but are not limited to: death; serious neck and spinal injuries that may result in complete or partial paralysis; brain damage; serious injury to virtually all bones, joints, ligaments, muscles, tendons, other aspects of the musculoskeletal system and vital organs; and serious impairment to other aspects of the body, general health, and well-being. I understand the dangers and risks of playing or practicing to play / participate in any sport or sport related activity may result not only in serious injury, but in a serious impairment of my (the participant's) future abilities to earn a living; to engage in other business, social and recreational activities; and generally enjoy life. Because of the dangers of playing or practicing to play / participate in any sport or sport related activity, I recognize the importance of following the coach's, official's and medical staff's instructions regarding playing techniques, training, and other team rules, etc., and agree to obey such instructions.

As the parent / legal guardian of the above named participant, I have read the above warnings and release, and understand its terms. I hereby agree to hold Memorial Day School, its direct and contracted employees, agents, representatives, coaches and volunteers, harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever that may arise by or in connection with participation of my child in any activities related to Memorial Day School activities. The terms hereof will serve as a release for my heirs, estate, executor, administrator, assignees, and for all members of my family. Whenever injury and / or sickness occur to the participant listed above, and the participant is under the supervision of Memorial Day School, and the participant's parent / legal guardian is unavailable to give his / her permission for treatment, the participant and others whose signatures are attached below do hereby give permission to authorize any emergency action necessary to ensure the safety of the child. The intention hereof being to grant authority to administer and perform all and singularly any examinations, pre-participation physical examinations, treatments, anesthetics, operations, and diagnostic procedures which may now, or during the course of this participant's care, be deemed advisable or necessary. This does not hold Memorial Day School financially responsible for any medical care given.

I specifically acknowledge that **Football, Soccer,** and **Wrestling** are **collision sports** that involve an even greater risk of injury than **contact sports**: **Basketball, Baseball, Cheerleading, Softball,** and **Volleyball** which involve greater risk of injury than **non-contact sports: Track & Field, Tennis, Cross Country, Rowing and Golf.**

_____ _____/_____/_____ _____ _____/_____/_____

PARTICIPANT'S SIGNATURE **DATE** **PARENT / GUARDIAN SIGNATURE** **DATE**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

GENERAL DISCLOSURE

I hereby authorize medical personnel to release information from my medical records for the purpose of payment, treatment or operations to their business associate partner which includes: the attending school's coaching staff and administrators; and any hospital in case of an emergency situation. This authorization shall be valid for the duration of the school year. It is subject to revocation by the patient, or the parent / guardian at any time except to the extent that action has been taken in reliance thereon. I am aware that once Memorial Day School discloses this information per my instructions, the information is subject to re-disclosure and may no longer be protected by the HIPAA (Health Insurance Portability and Accountability Act) of 1996. I understand that a photocopy of this authorization shall be as valid as the original. I know that I, or my authorized representative may receive a copy of this authorization upon request.

_____ _____/_____/_____ _____ _____/_____/_____

PARTICIPANT'S SIGNATURE **DATE** **PARENT / GUARDIAN SIGNATURE** **DATE**

If the athlete is physically unable to sign, please indicate such and identify the authority of the person to act who is signing for the athlete: _____

DISCLOSURE REQUIRING SPECIAL CONSENT

My signature below specifically authorizes the release of health care information relating to the testing, diagnosis, or treatment for (please check all that you wish released):

_____ HIV / AIDS Virus

_____ Mental Health / Psychiatric Disorders

_____ Sexually Transmitted Diseases

_____ Drug / Alcohol Abuse / Treatment

If treatment is rendered for HIV / AIDS, Hepatitis, Psychiatric and / or alcohol / drug abuse, this release will be restricted to a one-time release of information only:

_____ _____/_____/_____ _____ _____/_____/_____

PARTICIPANT'S SIGNATURE **DATE** **PARENT / GUARDIAN SIGNATURE** **DATE**

If the athlete is physically unable to sign, please indicate such and identify the authority of the person to act who is signing for the athlete: _____