HELP ONE CHILD's
Signs of Hope Camp

WAIVER AND RELEASE

Permission Form for Minors

Event: HELP ONE CHILD'S SIGNS OF HOPE CAMP Date of Event: AUGUST 6-10, 2017

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

Minor's Address: _____

I, _____, the undersigned parent, legal guardian, or foster parent of the above-named Minor(s), hereby give my permission for my child(ren)'s participation in Help One Child's "Signs of Hope Camp" held at Mission Springs Frontier Ranch from August 6-10, 2017 (the "Event"). I have directed my child(ren) to cooperate and conform to directions and instructions of persons responsible for the Event and/or their volunteers.

In signing this form, I warrant and represent that I am the parent, legal guardian, or foster parent of my child(ren), that I am 18 years of age or older; and I indemnify and hold harmless, release and discharge Help One Child and Mission Springs Association, Inc. and their constituent organizations, officers, agents, employees, and volunteers from any and all claims for personal injuries, property damage or wrongful death that my child(ren) may suffer as a result of participating in the Event, 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 of an injury as a result of my child(ren)'s participation in the Event, including transportation to and from the Event, 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, legal guardian, or foster parent, I am responsible for the health care decisions of my child(ren) and am authorized to consent to services to be rendered, and law requires no other consent.

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

I hereby authorize the making of photographs, motion pictures, videotapes, recordings, or other memorializing of said event and my child(ren)'s participation therein.

_____ _____

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*