St Helen Unicycle Team Member

Contact Information

Family Last Name _____

Rider's Name/s and ages: _____

Birthday: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Family e-mail: _____

Mother's Name: _____

Cell Phone: _____

Best Way Contacted: _____

Occupation: _____

Work Place: _____

Father's Name: _____

Cell Phone: _____

Best Way Contacted: _____

Occupation: _____

Work Place: _____

Child's Other Activities/Hobbies: _____

Allergies/ Medications: _____

Parent's Talents:
i.e.: Truck driver, mechanic, choreographer, cook, artist, designer, handyman/woman tailor, seamstress, other...

_____

_____

_____

ST. HELEN UNICYCLE TEAM

LIABILITY WAIVER FORM

CHILD'S NAME: _____

DATE OF BIRTH: _____

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ (H) PHONE # : _____ (C) PHONE # _____

MOTHER'S NAME: _____ FATHER'S NAME: _____

EMERGENCY CONTACT NAME: _____ PHONE #: _____

Participating in any activity requires an acceptance of the inherent risk of injury associated with that activity. I/We understand that serious injuries can happen to anyone, and specifically while participating in unicycling. With this understanding, the undersigned does hereby waive all liability and hold harmless and release The St. Helen Unicycle Team, St. Helen Parish, and the Catholic Diocese of Cleveland organizations, coaches, staff and sponsors for any injury that may occur to my child while he/she is participating in the unicycle program.

I/We give my/our consent and approval to the participation of our child in The St. Helen Unicycle Team's activities. I/We submit that my/our child is physically fit and has my/our permission to participate in The St. Helen Unicycle Team's activities. I/We hereby discharge, waive, and release The St. Helen Unicycle Team, St. Helen Parish, and the Catholic Diocese of Cleveland organizations, coaches, staff, and sponsors from all liability that may occur while participating in our unicycle program. I/We carry personal medical insurance for my/our child in case of accident, injury or illness.

PARENT/GUARDIAN SIGNATURE: _____ Date _____

PARENT/GUARDIAN SIGNATURE: _____ Date _____

St. Helen's Unicycle Team

Newbury, Ohio

Permission to Use Photograph:

I grant to St. Helen's Unicycle Team, its representatives and employees the right to take photographs of me/my child/children and my property in connection with the above-identified organization. I authorize St. Helen's Unicycle Team, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that St. Helen's Unicycle Team may use such photographs of me/my child/children with or without my name or child/children's name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising and Web content.

I have read and understand the above:

Child/Children Names: _____

Parent's Signature: _____

Parent's Printed Name: _____

St. Helen's Unicycle Team

ST HELEN'S UNICYCLE TEAM EMERGENCY MEDICAL AUTHORIZATION

Name: _____ School Year: _____

Address: _____ Student Grade: _____

_____ Phone: _____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under Unicycle Team authority and parents cannot be reached. The school recommends that parents have their signatures notarized.

Residential Parent or Guardian:

Mother's Name: _____ Daytime Phone: _____

Father's Name: _____ Daytime Phone: _____

Other's Name: _____ Daytime Phone: _____

Name of Relative or Childcare Provider:

_____ Relationship: _____

Address: _____ Daytime Phone: _____

_____

PART I or PART II MUST BE COMPLETED

PART I: **TO GRANT CONSENT**

I hereby give consent for the following medical care providers and local hospital to be called:

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Specialist: _____ Phone: _____

Hospital: _____ Emergency Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I give my consent for (1) the administration of any treatment deemed necessary by above named doctors or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted are as follows

:

_____

_____

Parent/Guardian Signature: _____ Date: _____

PART II: REFUSAL TO GRANT CONSENT

I **DO NOT** give my consent for the emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

Parent/Guardian Signature: _____ Date: _____