INDEMNIFICATION

CHILD'S NAME _____

ADDRESS _____

CITY,STATE,ZIP _____

Please List a contact person below in case of an emergency.

EMERGENCY CONTACT _____

ADDRESS _____

CITY,STATE,ZIP _____

PHONE # _____

PHYSICIAN TO BE CALLED _____

PHONE # _____

ADDRESS _____

CITY,STATE,ZIP_____

These authorizations are in effect _____
(Date)

_____ will be participating in the Saucon Valley Community Center _____Program. I will assume all risks and hazards incidental to participate in the above mentioned activity. I hereby waiver, release, indemnify, absolve and agree to hold harmless the Saucon Valley Community Center, its officers, staff, employees, agents, and participants for any claim whatsoever arising out of injury to my child and all claims regarding to personal property.

_____
(Signature of Parent or Guardian)

****

MEDICAL INFORMATION:

ALLERGIES

Food _____

Bee _____

Other _____

_____

ASTHMA

YES _____ NO _____

Inhaler YES _____ NO _____

LIMITATIONS _____

_____

OTHER PHYSICAL LIMITATIONS

_____

_____

_____