

PARTICIPANT'S MEDICAL & LIABILITY RELEASE

This form must be filled out completely and signed by parent/legal guardian if participant is under 18 years old

[print name of participant] _____ will participate in the Academic Decathlon taking place during the current academic school year.

Voluntary Release - Assumption of Risk and Indemnity Agreement: In consideration of the acceptance of the participant's involvement (*printed above*) in the Academic Decathlon, I hereby release, discharge, and covenant not to sue the Solano County Office of Education and other supporting County Office of Educations or any other sponsoring and supporting agencies and its agents, representatives, officers, their representatives, successors, and assignees, directors, staff, workers, participating volunteers, and all other hosts (herein collectively referred to as "releasees") from all claims and liability arising out of strict liability or ordinary negligence or hold harmless and cover releasee for all claim judgment(s) or expense(s) that may incur arising out of my child's participation in this event. I understand that participation in this event contains certain risks of injuries; that the meetings and events will be indoors and outdoors and that there is inherent risk in doing so which I voluntarily assume, because I choose to do so. I further know that other participants may pose a risk as there may be physical activities. I voluntarily elect to accept all risks connected with participation in this program.

Medical Consent: I, the undersigned, hereby give consent to have the above signed treated by a physician or surgeon in case of sudden illness or injury while participating in the Academic Decathlon; including, authorization and consent for any x-ray examination, medical anesthetic, or surgical diagnosis rendered under the general or special supervision of any member of the medical/dental staff and emergency room staff licensed under the provisions of the Medical Practice Act or Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It's understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and poser to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It's understood that efforts shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of Section 25.8 of the Civil code of the State of California. The signing of this release only gives the organizers of this program and agents thereof, the right to consent for treatment of minors. It does not release signee of liability from medical cost arising from said treatment. The releasees do not assume liability of said cost and is not liable for any complications arising from said treatment. It is understood that the releasees provide no medical insurance for such treatment. If a personal physician is listed, every effort will be made to contact such physician. However, the location of the event or the nature of the illness or injury may require the use of emergency medical personnel.

<i>Date of Last Tetanus Toxoid Booster Participant Received (if not dated, participant will receive a booster if a medical emergency warrants it)</i>	Insert Date:
-------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------

In the box below, indicate all of the participant's medical restrictions, [i.e., diabetes, allergies to medications and/or foods, heart problems, asthma, regular medication(s), etc.], in the space provided below. Please provide copies of prescription labels which identify medications and dosages. [Use back side for more space, if needed.] It is strongly recommended for participant to carry a medical card at all times.

Please Check the box if you do not carry Health/Medical Insurance.

Health Insurance Carrier & Phone: _____ (_____) _____

Medical Group (if available) & Policy Number: _____

Policy Holder's Name: _____

Holder's Relation To Participant: Father Mother Other _____

Family Physician & Phone: _____ (_____) _____

I have read and will abide by the guidance, rules, and regulations of this document and understand it is a release of all claims; assume all risk inherent in participation; and voluntarily sign below evidencing acceptance of the above provisions. This agreement shall apply to any accident occurring during the event and to any accident occurring within a period of two (2) years after the execution of this agreement.

Must be signed by parent or legal guardian if participant is under 18 years old _____
Today's Date

Print Name Of Signature Above _____
Relation To Participant