WAIVER AND RELEASE OF LIABILITY

I request for myself/my child to be allowed to participate in the BUDDY CLUB program and agree to the following:

1. I acknowledge and fully understand that I and/or the minor participant will be participating in activities associated with the Buddy Club program that may involve risk of personal injury, including permanent disability and death. I also acknowledge that there may be other risks not known to me or not reasonably foreseeable at this time.
2. I assume all the foregoing risks and accept personal responsibility for the damages following such injury, permanent disability or death.
3. Myself and my family release, waive, discharge and promise not to sue Society for disABILITIES, United Cerebral Palsy Association (UCP), Inc. of Stanislaus County, its volunteers, staff, executive director, and board of directors, and other participants of Buddy Club for any personal injury, property damage, or other damages that may arise from my participation in the Buddy Club program, regardless of whether such injury or damage is caused by negligence or carelessness.
4. I agree that photographs and/or my or my child's name may be published in, or used by Society for disABILITIES and/or UCP of Stanislaus County and any of the media or mass communication (including newspapers, magazines, television, pamphlets, brochures, newsletters, reports, etc.) without any liability on the part of Society for disABILITIES or UCP of Stanislaus County.
5. I have talked to my physician, who has acknowledged, that I or my child are physically capable to engage in the Buddy Club program with or without the use of adaptive equipment. I have given an accurate description of my or my child's disability and medical needs on the participant application.
6. I agree that the staff and volunteers of Buddy Club, Society for disABILITIES and/or UCP of Stanislaus County may authorize emergency medical treatment for myself, or for my child, up to and includ-ing emergency hospitalization and surgery. I give the Society and volunteer(s) the right to determine the appropriate medical facility/provider in the absence of the parent. I agree to be personally respon-sible for any related medical expenses.

I/WE HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTAND THAT I/WE HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, HAVE NOT CHANGED IT ORALLY, AND SIGN IT VOLUNTARILY.

*If participant is under 18 years of age or is unable to legally give effective consent, ***Parent/Guardian MUST sign below***

Participant Name:

_____

(PLEASE PRINT CLEARLY)

Parent/Guardian Signature: _____ Date:_____

Parent Name:

_____

(PLEASE PRINT CLEARLY)