WCTSMA MEDICAL LIABILITY RELEASE School _____

DIRECTIONS: Due to legal restrictions, it is necessary that all participants, parents/guardians, guests and WCTSMA Instructor complete this form to be eligible to attend any WCTSMA Leadership Conferences. This form should be returned to the WCTSMA Instructor who will retain a copy. The original forms must be maintained by the instructor.

PLEASE TYPE OR PRINT ALL INFORMATION

Participant Parent/Guardian
Name _____ Name_____
Home Address_____
Parent/Guardian/Telephone: Home: _____Work: _____Cell: _____
Student's Physician: _____Phone: _____
Physician's Address: _____
Emergency Contact: _____
Telephone Number: Home: _____Work: _____ Cell: _____
Local Advisor: _____School Name: _____

Student is covered by group or medical insurance: _____ Yes _____ No
If yes, complete the following information:
Name of insured: _____Insurance Company: _____
Group #: _____Policy #: _____

Please completely describe any medical condition, which may recur or be a factor in medical treatment:
a. Allergies: _____ e. Physical Handicap: _____
b. Convulsions: _____ f. Medicine Reactions: _____
c. Blackouts: _____ g. Disease of any kind: _____
d. Heart/lung problems: _____ h. Other (Be specific):_____

If currently taking medication, please provide the following information:
Name of medication: _____Prescribing Physician/Phone Number: _____

LIABILITY RELEASE: I certify that the information described above is accurate and complete to the best of my knowledge. I understand that each individual is responsible for his/her own insurance coverage during any WCTSMA related trip. I hereby release WCTSMA Board of Directors, the WCTSMA Staff, WCTMSA, and any designated individual in charge of the WCTSMA group or specific activity from any legal or financial responsibility with respect to my personal or my student/child's participation in or contact with any known element associated with an activity including competitive events.

PARENT/GUARDIAN: Please check one of the following and sign your name.

- ☐ I give my permission for immediate medical treatment as required in the judgment of the attending physician. Notify me and/or any persons listed above as soon as possible.
- ☐ I do not give permission for medical treatment until I have been contacted, except in the case of an emergency.

Any dispute arising from this release shall be submitted to a neutral mediator to assist the parties in resolving the dispute prior to initiating any legal processes.

Parent/Guardian's Signature: _____ Date _____
(Applicable for delegates under the age of 18 and must be signed by the parent or legal guardian.)

Participant's Signature: _____ Date _____

Instructor's Signature: _____ Date _____