STUDENT LIABILITY WAIVER
Form must be completed for *each student* by their parents

Student's name: ________________________________ Grade: ____________________________

Parent's Name: _________________________________

Age: _____ Date of Birth: ___/___/___ Diet: Vegetarian _____ Gluten-Free _____ Dairy_____ Other ________________

Cell Phone: _______________________ Ok to text? _____ Email: ____

Home address: ____

Home/cell phone: ______________________________________ Business phone: ______________________________

GENERAL RELEASE OF LIABILITY, INDEMNIFICATION AGREEMENT & MEDICAL RELEASE

I, ____, agree on behalf of myself, my heirs, assigns, executors,
Print Full Name
and personal representatives, to hold harmless, and defend ____,
Parish/School Name

Holy Spirit Academy, its officers, directors, agents, employees and representatives ("Releasees") associated with the events and activities from any all liability claims, injury, loss and damage arising from or in connection with participation in the school and school-related events and activities of Holy Spirit Academy.

Further, I AGREE to hold Releasees harmless and indemnify Releasees for any claim or cause of action whatsoever arising out of the above event and activities which take place during the above identified dates that is brought against Releasees by myself or my family members, heirs, assigns, executors and personal representatives.

I UNDERSTAND that participation at Holy Spirit Academy may entail danger and risk of injury. The inherent danger is understood and voluntarily assumed.

I HAVE READ THIS DOCUMENT. I UNDERSTAND IT IS A RELEASE OF ALL CLAIMS. I UNDERSTAND I ASSUME ALL RISK INHERENT IN THIS ACTIVITY. I VOLUNTARILY SIGN MY NAME EVIDENCING MY ACCEPTANCE OF THESE PROVISIONS.

____ ___________________________
Parent Signature Date

EMERGENCY MEDICAL TREATMENT: In the event that I should require medical treatment and I am not able to communicate my desires to attending physicians or other medical personnel, I give permission for the necessary emergency treatment to be administered. Please advise the doctors that I have the following allergies and/or other health conditions: ____

<u>In case of an emergency and for permission for treatment beyond emergency procedures, please contact:</u>
Name: ____ Relationship to me: __________________________________
Daytime Phone: ___________________________ Night time phone: _____________________________
Health Insurance Carrier: ____
Insurance ID Number: __________________________Insurance Policy Number: __________________

____ ___________________________
Signature Date