



STUDENT EXTRACURRICULAR 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: _____

In case of an emergency and for permission for treatment beyond emergency procedures, please contact:

Name: _____ Relationship to me: _____
Daytime Phone: _____ Night time phone: _____
Health Insurance Carrier: _____
Insurance ID Number: _____ Insurance Policy Number: _____

Signature _____
Date