

In order for a child to participate in FIT activities, his or her legal parent or guardian must sign the following waivers.

### GENERAL WAIVER OF LIABILITY

As to activities on the property of Hanna Perkins and all other locations in which services are provided by Western Reserve Speech & Language Partners (WRSLP) and the Friendship In Teams Program (FIT) (collectively, "Businesses"), I agree on behalf of myself, my child, and any related parties and agents (collectively "Participant(s)"), and my and their representatives, heirs, successors, and assigns to hereby and forever hold the Businesses and its respective employees, agents, representatives, heirs, successors and assigns harmless from and against any claim at law or equity, demand, lawsuit, cause of action, and/or damage or loss of any kind or nature, whether arising out of contract, tort, or otherwise, which we now have or may in the future have against the Businesses, relating directly or indirectly to, or arising out of, the Participants' involvement with the Businesses in the FIT Program. I UNDERSTAND THAT THE SIGNING OF THIS WAIVER OF LIABILITY MEANS THAT NEITHER I NOR THE PARTICIPANT(S) NOR ANY OTHER REPRESENTATIVE OF THE PARTICIPANT(S) MAY SEEK LEGAL OR EQUITABLE RELIEF AGAINST THE BUSINESSES DIRECTLY OR INDIRECTLY RELATED TO THE FIT PROGRAM.

### WAIVER OF LIABILITY FOR FIT/WRSLP EMPLOYEES

Any responsibility held by WRSLP and The FIT Program for their respective employees, consultants and agents (collectively, "Persons") shall be limited to the normal business operations of the Businesses. The Businesses hereby disclaim any and all liability arising from the activities of such Persons outside of the Businesses. Said disclaimed activities include, without limitation, any transportation, outside care, or any other service provided on an individual or collective basis by such Persons. To the extent Participants choose to engage any such Person(s) to provide services outside of the Businesses, I agree on behalf of myself, my child, and any related parties and agents, and my and their representatives, heirs, successors, and assigns to hereby and forever assume complete risk and/or liability directly or indirectly related to any such services.

I, the undersigned, am the parent or legal guardian of \_\_\_\_\_, with full authority to execute this waiver of liability. I read, understand, and agree to both of the above waivers of liability.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

In order for a child to participate in FIT activities,  
his or her legal parent or guardian must complete either Part 1 or Part II below.

**CONSENT FOR TREATMENT**

PLEASE COMPLETE PART I OR PART II

Name of child: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**PART I (To Grant Consent)**

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor \_\_\_\_\_ Telephone \_\_\_\_\_

Dentist \_\_\_\_\_ Telephone \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Telephone \_\_\_\_\_

Hospital \_\_\_\_\_ Telephone \_\_\_\_\_

In the event reasonable attempts to contact me or the other parent at the phone number(s) provided on the on the FIT Registration Form have been unsuccessful, I hereby give my consent for (1) the admission of any treatment deemed necessary by the above named doctors or above preferred dentist, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the above preferred hospital or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including ALLERGIES and any PHYSICAL IMPAIRMENTS to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_

Wears Contacts? YES NO Uses an inhaler? YES NO Has an EPIPEN? YES NO

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**PART II (Refusal for Consent)**

I DO NOT GIVE MY CONSENT for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the FIT™ Program(s) to take no action or to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_