



# WARRIOR

## ***Summer Sport Camp Release Form***

### **A PARENT OR LEGAL GUARDIAN MUST SIGN**

I am the parent or legal guardian of this participant and am authorized to execute this release, and hereby grant my permission for him/her to participate fully in the sport camp listed below.

I, and my heirs, in consideration of the listed child participating in the said summer sports camp hereby release the supervising staff and coaches of Little Rock Christian Academy, the Board of Trust of the Little Rock Christian Academy, its officers, employees and agents, and any other people officially connected with this event, from any and all liability for damage to or loss of personal property, sickness or injury from whatever source, legal entanglements, imprisonment, death, or loss of money, which might occur while participating in this event.

Specifically, I release said persons from any liability or responsibility for the physical condition of the listed participant and for the presence or actions of any other participants. I am aware of the risks of participation, which include, but are not limited to, the possibility of sprained muscles and ligaments, broken bones and fatigue. I hereby state that the listed participant is in sufficient physical condition to accept a rigorous level of physical activity, and therefore I give permission for nonprescription medication (i.e. Tylenol) and routine non-surgical medical care to be given to my child if deemed necessary by the supervising camp staff and to take the listed participant to a doctor or hospital, and hereby authorize medical treatment including, but not limited to, emergency surgery or medical treatment.

I understand that participation in this program is strictly voluntary and I freely chose to allow the listed child to participate. I understand that Little Rock Christian does not provide medical coverage for me and that I will assume the responsibility for all medical bills.

Name of Sport camp participating: \_\_\_\_\_

Custodial Parent /Guardian Signature \_\_\_\_\_

Hm Ph. \_\_\_\_\_ Cell Phone \_\_\_\_\_

Alternate Emergency Contact Name \_\_\_\_\_

Alternate Emergency Contact Phone \_\_\_\_\_

Name of Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Policy Number \_\_\_\_\_

Any Known Allergies (including food): \_\_\_\_\_

Please list any other conditions you feel the supervising staff should know about the participant (use the back of this sheet if necessary)