

**PARENT'S APPROVAL, STUDENT WAIVER,
AND PARTICIPANTS' WAIVER**

Print the name of all family members who may participate in any PTA sponsored events for the [insert period] school year (including student, siblings and parents):

1. _____
Participant Name Age, if minor child
2. _____
Participant Name Age, if minor child
3. _____
Participant Name Age, if minor child
4. _____
Participant Name Age, if minor child

The undersigned parent(s) or guardian(s) assume all risks in connection with the participation of all individuals listed above in any and all of the PTA sponsored activities.

I attest and verify that all individuals listed above are physically fit and able to participate in any PTA sponsored activities. Further I acknowledge that it is my responsibility to understand any inherent risks associated with PTA sponsored activities and communicate those risks to all individuals named above.

I do hereby certify that to the best of my knowledge and belief all individuals named above are in good health. In the event that I, or other parent/guardian, cannot be reached in an emergency, I hereby give permission to secure proper treatment for my child(ren). I/we do hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of the medical staff of the hospital or facility furnishing medical or dental services. It is further understood that the undersigned will assume full responsibility for any such action, including payment of costs.

I/we hereby advise that the above named minor(s) has the following allergies, medicine reactions or unusual physical conditions, which should be made known to a treating physician: (If none, please write the word "none". If yes, put first name of child and the allergy/condition.): _____

I/we, as parent(s) or guardian(s) of the minor(s), do hereby, for my child/children, myself, my heirs, executors and administrators, release and forever discharge and hold harmless the Maryland State PTA, the local PTA and all officers, directors, employees, agents and volunteers of the organizations, acting officially or otherwise, from any and all claims, demands, actions or causes of action which in any way arise from the participation of any individuals listed above in any PTA sponsored activities.

By signing below, I confirm that I have carefully read and fully understand its contents. I am aware that this is a release of liability and signed it of my own free will.

1. _____
Parent/Guardian Signature Print Name Date
2. _____
Parent/Guardian Signature Print Name Date

Address City State Zip Phone (incl area code)

APROBACIÓN DE PADRES Y EXENCIÓN POR EL ALUMNO
(PARENT'S APPROVAL AND STUDENT WAIVER)

_____ (*nombre del menor*) tiene mi (nuestro) permiso para tomar parte en todas las actividades patrocinadas por la PTA (Asociación de Padres y Maestros) durante el año escolar 201_ a 201_.

El infrascrito padre o tutor legal asume todo riesgo con respecto a la participación del estudiante en cualquier y toda actividad patrocinada por la PTA. Yo (nosotros) por la presente libero y descargo a la PTA de Maryland, a todos los funcionarios de la PTA, a los empleados y a los agentes de toda obligación, reclamo o demanda por cualquier daño, pérdida o herida al estudiante, daños o pérdida de la propiedad del estudiante o de la propiedad del padre con respecto a la participación en estas actividades, a menos que fuese causado por la negligencia de la PTA.

Yo (nosotros) por la presente certifico que a mi (nuestro) leal saber y entender el menor se encuentra en buen estado de salud. En caso de enfermedad o accidente, se autoriza administrar tratamiento médico de emergencia. Además se acuerda que el infrascrito asumirá responsabilidad total por cualquiera de estas acciones, inclusive el pago de costos.

Yo (nosotros) por la presente informo que el menor arriba nombrado sufre de las alergias siguientes/es sensible a los medicamentos siguientes y/o tiene la condición limitante siguiente que podría afectar su participación, y de lo cual debe informarse al médico que trate la emergencia:

Si no tiene ninguno, por favor escriba "ninguno"

1. _____
Firma Fecha

Nombre impreso ()
Teléfono

Dirección Ciudad Estado Código Postal

2. _____
Firma Fecha

Nombre impreso ()
Teléfono

Dirección Ciudad Estado Código Postal