Sullivan-Okaw Valley High School Weightlifting

Medical Treatment & Waiver of Liability Release

Event:

My son/daughter may participate in a contest of an athletic/powerlifting nature through Sullivan-Okaw Valley High Schools. I understand that school transportation will be provided, and if I choose to be responsible for my child's transportation I must provide a signed note to the sponsor prior to the meet. I understand that the participation of my son/daughter in these athletic events/power lifting involves risk of injury (or death) to him/her and his/her property and that no amount of precaution by the supervisors/coaches can eliminate such risk. Because of this and in consideration of the participating schools' willingness to sponsor/participate in the athletic event/power lifting and to allow my son/daughter to participate, I agree as follows:

1. My son/daughter is adequately physically fit to participate in a powerlifting/athletic event and does not currently have injuries that could be aggravated by participation in the event.
2. My son/daughter will participate in the event in a careful and prudent manner and will attempt whenever possible to minimize the risk of injury to him/her and to others.
3. I hereby release Sullivan/Okaw Valley high schools and other participating schools, their agents, officers, employees and trustees from liability for any and all injuries to my son/daughter or his/her property suffered at, or arising out of the power lifting event, or travel to the event. I sign this waiver and release intending to legally bind myself and my heirs, representatives, successors, and assigns.
4. I hereby authorize the meet directors and sponsors to act in the best interests of my son/daughter in seeking medical attention in the event of an accident.

I HAVE CAREFULLY READ THIS RELEASE AND WAIVER OF LIABILITY/CONSENT FOR MEDICAL CARE. I UNDERSTAND ITS TERMS AND HAVE SIGNED VOLUNTARILY.

Parent or Legal Guardian Name/Signature:_____Date:_____

Phone Number in Case of Emergency: _____

Participant's Signature: _____Date:_____

Health Insurance Provider/ Policy Number:_____