

CASP Authorization for Medical Treatment / Release Form

2011-2012

Please know that in the unlikely event of a medical/dental emergency CASP staff will make every effort to reach you. However, if we cannot reach you and a medical or dental professional feels that a delay in treatment could/would be detrimental to your child's health, we would like to have your written permission on hand authorizing that treatment of your child begin.

Please read and sign the following.

Thank you.

I authorize (child's name) _____ to participate in the Canyon After School Program (CASP). In the event of illness or injury, I consent to whatever examination, x-ray, anesthetic, medical, dental or surgical treatment and /or hospital care that is considered necessary in the best judgment of the attending physician, dentist, or surgeon.

I hereby voluntarily and knowingly release and discharge Canyon Elementary School and Canyon After School Program, its officers, directors, agents, employees, and volunteers, acting officially or otherwise, of and from any and all claims, demands, actions, or causes of action of any kind which in any way arise out of or relate to my child's participation in CASP. I hereby waive my right to make any claim against Canyon Elementary School and CASP, its officers, directors, agents, employees, and volunteers, and agree to indemnify and hold harmless said parties from all claims and/or liabilities arising out of my child(ren)'s participation in CASP.

Parent's Name
(please print)

Parent's Signature

Today's Date