DISABILITY SERVICES RESOURCE CENTER
1820 N. Trumbull Drive, Bay City, MI 48708-5444
dsrcbc@gmail.com www.dsrcbc.org
PHONE: 989-895-5444 FAX: 989-895-3917

INSURANCE WAIVER and RELEASE of LIABILITY

In consideration of being allowed to participate in any way in Disability Services Resource Center (hereinafter known as DSRC) programs, related events and activities, I and/or the minor participant, for myself, and on behalf of my heirs, assigns, personal representatives and next of kin, the undersigned:

1. Agree that prior to participating, I will inspect, or if a parent and or legal guardian I will instruct the minor participant to inspect, the facilities and equipment to be used, and if I believe to the best of my ability that anything is unsafe, I and/or the minor participant will immediately advise DSRC of such condition(s) and refuse to participate.
2. Acknowledge and fully understand that I and/or the minor participant, will be engaging in activities that involve risk of serious injury, including permanent disability and death, and severe social and economic losses which might result only from my actions, inactions or negligence of others, or the condition of the premises of any equipment used. Further, that there may be other risks not known to me or not reasonably foreseeable at this time.
3. Assume all the forgoing risks and accept personal responsibly for the damages following such injury permanent disability, or death.
4. Release, waive, discharge and covenant not to sue DSRC, its affiliations, representatives, administrators, directors, agents, coaches, and/or employees of the organization, other participants, sponsoring agencies, sponsors, advertisers, their heirs, and if applicable, owners and leasers of premises used to conduct the event, all of which are (hereinafter referred to as releasees) from demands, losses or damage on account of injury, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the releasees or otherwise.
5. Give permission to use any photographs, videotapes or films, or mention of me in a story or article publicity and/or promotion.

I/WE HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTAND THAT I/WE HAVE GIVEN UP THE SUBSTANTIAL RIGHTS BY SIGNING IT, HAVE NOT CHANGED IT ORALLY, AND SIGN IT VOLUNTARILY. I/WE UNDERSTAND THAT THE ABOVE APPLIES NOT ONLY TO THE EVENT OR PROGRAM, BUT ALSO TO INSTRUCTION AND LOANING OF DISABILITY SERVICES RESOURCE CENTER EQUIPMENT.

_____ _____

PARTICIPANT'S SIGNATURE **PRINT PARTICIPANT'S NAME**

ADDRESS: _____ **CITY & ZIP:** _____

DATE: _____ **PHONE:** _____ **BIRTHDATE:** _____ **EMAIL:** _____

FOR PARTICIPANTS OF MINORITY AGE

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree his/her release as provided above of the Releasees, and for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releasees from any and all liabilities incident to minor child's involvement or participation in these programs as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE.

_____ _____

1st Parent's Signature & Emergency Phone Printed Name & Date

_____ _____

2nd Parent's Signature & Emergency Phone Printed Name & Date

Note: If 2nd parent/guardian signature is not possible, 1st parent certifies that the 2nd parent or guardian has authorized participant to pursue this activity and 2nd parent/guardian agrees to all items above.

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MEDIA RELEASE FORM

Must be filled out by all athletes, helpers, youth, volunteers and parent helpers.

Printed Name of Participant: _____

Select one of the following:

☐ I hereby give permission to the Disability Services Resource Center to release photos, videos, names, statements, and parent information to all media sources, and for grant resources and general program publicity.

OR

☐ I do not wish to have information/photos released to media or other sources.

Participant Signature: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Parent's Signature: _____

(If athlete/helper/volunteer is under 18 years of age)

Date: _____

This Media Release Form is valid until both parties acknowledge a release of it in writing.

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Medical Release/Health Examination Form

MEDICAL RELEASE (to be completed by **Legal Guardian**)

Participant's Name _____ Date of Birth _____

If the participant will need medication while in our care, provide, for each medication, its name, dosage amount, and dispensing time(s) _____

_____

_____

Participant's known allergies _____

_____

Does, or should, the participant have any limitations on physical activity? ☐YES ☐NO

Does the participant wear hearing aids, glasses, contact lenses, or other devices? ☐YES ☐NO

Has the participant ever lost consciousness during physical activity? ☐YES ☐NO

Does the participant have any seizure disorders? ☐YES ☐NO

If the answer to any of the questions above is YES, please specify _____

_____

I, (Legal Guardian, please print) _____, **consent to the participation of the above-named participant in Disability Services Resource Center's**

☐Summer Special Needs Enrichment Programs ☐ACES Softball ☐Wheelers & Dealers Bowling ☐Other _____ _____

I also agree to emergency medical treatment, if deemed necessary.

_____ _____

Legal Guardian's Signature Date

HEALTH EXAMINATION (to be completed by **Physician** prior to start of program)

Participant's Name _____ Date of Birth _____

Height _____ Weight _____ B/P _____ Pulse _____

Abnormal Physical Findings _____

_____

Recommendations/Limitations _____

_____

Physician's Name (please print) _____

Street Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

_____ _____

Physician's Signature Date