

PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

PARTICIPANT'S NAME: _____

BIRTH DATE: _____

SEX: _____

PARENT/GUARDIAN'S NAME:

HOME ADDRESS

HOME PHONE: _____

BUSINESS PHONE: _____

I, (name of parent or guardian) _____, grant permission for my child _____ to participate in this Egypt Cares Family Foundation activity that requires transportation to a location away from the drop off site. This activity will take place under the guidance and direction of foundation volunteers for the "Rising Media Stars Day Camp". Children will participate in tours of various media properties.

As parent, and/or legal guardian, I remain legally responsible for any personal actions taken by the above named young person (participant).

I agree on behalf of myself, my child's other parent if known or living (name of parent) _____, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend the Egypt Cares Family Foundation, its officers, directors and agents, or representatives associated with the event with respect to any and all actions, claims or demands that may be made or brought against the foundation, its officers, directors and agents, and representatives associated with the event, arising from or in connection with my child's attending the event or in connection with any illness or injury or cost of

medical treatment in connection therewith, and I agree to compensate the foundation, its officers, directors and agents, or representative associated with the event for reasonable attorney's fees and expenses arising in connection therewith.

Signature _____

Date _____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. Of the following statements pertaining to medical matters, sign only those in accordance with your wishes:

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

NAME & RELATIONSHIP: _____

PHONE _____

FAMILY DOCTOR _____

PHONE _____

FAMILY HEALTH PLAN CARRIER: _____

POLICY NUMBER: _____

Signature _____

Date _____

Date _____

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage are as follows:

Signature _____

Date _____

No medication of any type whether prescription or nonprescription may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature _____

Date _____

I hereby grant permission for nonprescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child if deemed advisable

Signature _____

Date _____

Special Medical Information: The foundation will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.)

Immunizations: Date of last tetanus/diphtheria immunization

Does child have a medically prescribed diet?

Any physical limitations?

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, date and disease or condition. _____

You should be aware of these special medical conditions of my child.
