THE ANCHOR
Sign-Up & Release Form

Activity Title: ______________________________ **Date(s)** ___________ **To** ___________
(Please print)
Student Name: ________________________________ **Phone #** __________________

Address: _________________________________ City: _____________ Zip: _________

(PLEASE READ CAREFULLY & FILL OUT COMPLETELY)

I hereby give my permission for my son/daughter to participate in this activity. As the legal parent/guardian of the above, I assume all and full responsibility and liability for any illness, disease, infirmity or alteration in physical condition sustained by any person for any reason whatsoever. I hereby release The Anchor, its employees and its officers (including 'drivers' helping in the transportation of students in an activity) from any and all responsibility and liability in case of illness, accident injury or death and hereby authorize any medical care deemed necessary by an accredited physician, nurse, paramedic, hospital or emergency medical staff while involved in the aforementioned activity. In the event of illness, accident or injury, while the student is in the care of The Anchor, I understand and agree that I am financially responsible for any care so provided.

In the event that it becomes necessary or advisable for any reason whatsoever to alter the itinerary arrangements, the leadership reserves the right to make such alterations.

I understand that I will be required to pick-up the aforementioned student at the request of the leaders of this activity if the participant's behavior is contrary to the spirit and intent of this activity.
The signing of this form by the parents or legal guardian shall be deemed consent to the above conditions.

______________________________ ______________________________ ___________
Parent or guardian Print / Sign Date

______________________________ ______________________________ ___________
Parent or guardian Print / Sign Date

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Though we do not anticipate any problems, your child may not be treated by a physician without parental authorization. In the event that such treatment is necessary, you will be called immediately, if possible. If immediate treatment is deemed necessary, we must have your authorization. We want you to be aware that your child will be protected in every way reasonably possible.

Please list any pertinent health information below. Include allergies, drug reactions, chronic ailments and/or prescription medications.

Physician Name ____ Phone#______________________

Parent/Guardian Name ____

Phone # ___________________________ Phone # ___________________________ Phone # _____________________

Alternate Emergency Contact: ________________________________ Phone# _____________________________

Medical Insurance Company __________________________________ Medical Insurance Phone # _________________

Member ID# ___________________________________

Allergies ____

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370-A Tomkins Ct Gilroy, Ca 95020 (408) 848-1218