

# Best Cheerleading Camp Minor Release/Waiver Form

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
School Name \_\_\_\_\_

I/we, \_\_\_\_\_, parent(s)/legal guardian(s) of \_\_\_\_\_ (hereinafter "son/daughter"), hereby waive for myself/ourselves and on behalf of my/our son/daughter any claims or causes of action for death, personal injury, property damage or otherwise which he/she or I/we may now have or hereafter have against BEST Cheerleading arising out of my son/daughter's participation in the cheerleading activities at \_\_\_\_\_ (camp location) on \_\_\_\_\_ (camp dates), including, without limitation, all claims or causes of action for death, personal injury, property damage or otherwise resulting from the risks inherent in cheerleading activities, including without limitation, falls.

I/we hereby grant BEST Cheerleading the exclusive right to photograph and/or use my son/daughter's name, face, likeness, and appearance in advertising and promotions relating to BEST Cheerleading without reservation or limitation. In granting this license, I/we understand that BEST Cheerleading is not under any obligation to exercise any of their rights, licenses and privileges herein granted.

I/we authorize BEST Cheerleading to procure, at my/our expense, any medical care reasonably required by my/our son/daughter during his/her visit at hospitals or facilities chosen by BEST Cheerleading.

Further, I/we represent that any medication to which my/our son/daughter is allergic or currently taking is listed below and will ensure that my/our son/daughter brings such medication with him/her to BEST Cheerleading Camp if necessary and that my/our son/daughter is responsible for consuming the prescribed dosage.

## Family and Medical Information

Parent/Guardian Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Emergency Contact \_\_\_\_\_  
Relationship to Participant \_\_\_\_\_ Phone \_\_\_\_\_  
Medications (if any): \_\_\_\_\_  
Allergic to (if any): \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date