

PLEASE PRINT

SOUTHERN CALIFORNIA MUNICIPAL ATHLETIC FEDERATION (SCMAF)

MINOR RELEASE FORM AND CONSENT FOR TREATMENT

CHILD'S NAME: First Last ACTIVITY:

MALE FEMALE DATE OF BIRTH: SCHOOL:

PARENT OR GUARDIAN: First Last

ADDRESS: City State Zip

HOME PHONE: CELL PHONE:

E-MAIL ADDRESS (PARENT/GUARDIAN):

RELEASE

I give permission for the minor in my custody to participate in the above-mentioned activity and hereby waive, release and discharge any and all claims or rights to claims for damages for death, personal injury or property damage which I may have, or accrue to me, as a result of said minor's participation in said activity.

I further understand that serious accidents occasionally occur during said activity, and that participants in such activity occasionally sustain mortal or serious personal injuries, and/or property damages, as a consequence thereof.

It is further understood and agreed that this waiver, release and assumption of risk is to be binding on my heirs and assigns.

I also hereby agree to Grant to the Southern California Municipal Athletic Federation (SCMAF), the right to use name, likeness, portrait, recorded voice, and biographical material in order to advertise, promote, and publicize SCMAF, but not, as an endorsement of any product or service of any advertiser.

I agree to accept and abide by the rules and regulations of the Southern California Municipal Athletic Federation.

Date Signature of parent or guardian

CONSENT TO TREATMENT OF MINOR

*In the event of sudden illness, accident or injury which may occur while said minor is engaged in an activity supervised by the Southern California Municipal Athletic Federation and their representatives, agents or assignees, when neither the parents, guardian or designated family physician can be contacted, I hereby give my consent pursuant to California Civil Code #25.8 for emergency treatment as shall be necessary under the circumstances by any physician licensed under the Laws of the State of California.

Date Signature of parent or guardian

Family Physician:

Telephone:

Insurance Co.: Type of Coverage:

Pertinent medical history information (Epilepsy, Diabetes, Allergies, etc.)

Emergency Number (other than parents): 1. Name Phone