

**Beth Haven Christian School  
5515 Johnsontown Road  
Louisville, Kentucky 40272  
502-937-3516**

**PARTICIPANT/PARENT/GUARDIAN WAIVER AND INDEMNITY AGREEMENT FOR**

**SPORT:** \_\_\_\_\_

**SCHOOL YEAR:** \_\_\_\_\_

**STUDENT'S NAME:** \_\_\_\_\_

In consideration of accepting me or my child for participation in the above named program or activity I hereby, for myself, my heirs, executors, and administrators, waive and release any and all rights and all rights and claims for damages that I may have against the above named organization and its agents, employees, representatives, successors, and assigns for any and all injuries suffered myself or my child that arise out of the above named program or activity sponsored by the above by named organization. This waiver and release is intended to include, but is not limited to other activities in which my child, or myself may participate associated with the following events.

I warrant that I have the right to authorize the foregoing and do hereby agree to hold the above named organization harmless of and from any and all liability of whatever nature which may arise out of or result from such participation.

For the consideration stated above, I further agree that in the event that my child or I should make any claim against the above named organization for damages arising out of the above named program or activity I will personally indemnify, defend, and hold harmless the organization and its agents, employees, representatives, successors, and assigns against any and all loss and damage occasioned thereby, including attorney's fees.

Please note: All athletic uniforms are the sole property of BHCS and will be returned at the end of the season or immediately if student ceases to participate. Failure to do so will result in parent being billed for the cost of the uniform.

I have read and understand this Agreement and have willingly placed my signature below as evidence of my acceptance of all the conditions contained herein.

\_\_\_\_\_  
**PARENT'S SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
GUARDIAN SIGNATURE (if participant is a minor)

\_\_\_\_\_  
DATE

**PLEASE NOTE IMPORTANT INFORMATION BELOW**

I am aware that participation in this program or activity may be a dangerous activity involving MANY RISKS OF INJURY. I understand the dangers and risks of participating include, but are not limited to, death, serious neck or spinal injury, which may result in paralysis, brain damage, serious injury to all internal organs, injury to all bones, ligaments, muscles, tendons, and other aspects of my child's body. I understand the dangers and risks of playing or practicing may result not only in serious injury, but in serious impairment of future ability to earn a living, engage in business, and generally enjoy life.

Because of the dangers of the program or activity I understand the importance of following the director's instructions and rules and agree to obey instructions.

In consideration for allowing me or my child to participate, I hereby assume all the risks associated with the activity and agree to hold the school district, its employees or agents harmless from any and all liability, causes of action, debts, claims, or demands of any nature whatsoever which may arise in connection with my participation in any activities related to the school. The terms hereof serve as a release and assumption of risk for my heir, estate, and all for members of my family.

I, as the parent/legal guardian, have read the above warning and release and understand its terms. I understand the program or activity involves many risks, including but not limited to those outlined above.

**Beth Haven Christian School Medical Permission Slip**

TO: ANY HOSPITAL, CLINIC, OR PHYSICIAN

I/we, the undersigned parent, parents, or legal guardian(s) of \_\_\_\_\_

Authorize any hospital or clinic or licensed physician to treat my/our child with any x-ray examination, anesthetic, medical, or surgical treatment. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power to render care which the physician in the exercise of his best judgment may deem advisable. It is understood that responsible effort shall be made by the respective school representative (or any other personnel) to contact the undersigned prior to rendering the treatment to the patient, but that treatment will not be withheld if the undersigned cannot be reached. \*\*\* **If there is an injury: parent & coach both must fill out an injury form and return to school office within 48 hours\*\*\***

**within 48 hours\*\*\***

List any restrictions to your authorization to treat below:

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home/Cell Phone

\_\_\_\_\_  
Emergency Phone

**THIS FORM MUST BE ON FILE IN THE SCHOOL OFFICE PRIOR TO ANY STUDENT ACTIVITY**

**Revised 02/21/2017**