Declaration of Consent

Please indicate your consent to each item by signing below each statement.

Emergency Medical Treatment Consent

1. I, __________________, parent/guardian of ______________ give permission to the medical personnel selected by SOAR Special Needs to order hospitalization, treatment, anesthesia, and surgery if necessary, in case of an emergency when parents cannot be reached.

_________________________            __________________
Signature                                                           Date

Photograph Release Consent

2. I, __________________, parent/guardian of ______________ give SOAR Special Needs permission to use my child’s name and/or picture in presentations, media releases, newsletters and marketing materials solely for the purpose of promoting the SOAR Special Needs.

_________________________   _________________________
Signature                                                         Date

Waiver of Liability Consent

3. I, __________________, parent/guardian of __________________ agree to release SOAR Special Needs and event host facility and all staff and volunteers from all liability for any additional illness or injury to my child, and for any accidental damage or destruction of my child’s property during the provision of respite care services.

_________________________   _______________________ 
Signature                                                         Date

Thank you for your cooperation.  If you have any questions, please contact Kristina Bundy, SOAR Activities Director, 816-782-SOAR (7627). info@soarspecialneeds.org.