



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 and I Can Therapy, LLC 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 and I Can Therapy, LLC 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, I Can Therapy, LLC 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 SOAR Special Needs at 816-782-SOAR (7627) or info@soarspecialneeds.org.