®

PERMISSION TO PARTICIPATE, RELEASE OF ALL CLAIMS AND AUTHORIZATION FOR MEDICAL TREATMENT

I hereby give myself/my child **(print full name)**_____
permission to attend martial arts classes at Whole Armor Martial Arts Inc., Vancouver Washington.

I hereby release and agree to hold harmless, Whole Armor Martial Arts Inc. together with its agents and employees from all actions, causes of action, damages, claims or demands which I, my heirs, executors, administrators or assigns may have against Whole Armor Martial Arts Inc. for all personal injuries, loss, or damage, known or unknown, which me/my child may incur by participating in the above activity.

I, the undersigned, have read this release and understand all its terms. I execute it voluntarily and with knowledge of its significance. I have made, constituted and appointed, and by these present do make, constitute and appoint any agent of Whole Armor Martial Arts Inc., their true and lawful attorney-in-fact for them and in their name, place and stead, and for their use and benefit to admit me/my child to any hospital or clinic and to authorize any medical treatment, including surgery, in the event of emergency illness, as Whole Armor Martial Arts Inc. may deem appropriate. Any hospital, clinic or doctor may rely on a telephonic communication reasonably believed to be from an agent of Whole Armor Martial Arts Inc..

I further agree to assume full financial responsibility for any and all charges incurred, specifically including ambulance, doctor, hospital or medication. the original of the Agreement shall be irrevocable until physically destroyed. Any party relying on this Agreement is hereby released from any liability by reason of relying on this Agreement, or by this Agreement having been revoked without his/her knowledge. I am authorized to give this Limited Power of Attorney.

I further promise to hold harmless Whole Armor Martial Arts Inc. and/or its employees and agents from any and all expense incurred pursuant to this authorization in obtaining medical treatment and/or transfer, including but not limited to: ambulance expense, costs of paramedics, hospital expense, and/or physician charges. The following information is needed by any hospital or practitioner not having access to my/my childs medical history:

Allergies:_____

Medications being taken:_____

Date of last tetanus shot:_____

Physical impairments:_____

Name of physician and phone number:_____

Restrictions on participation:_____

Other pertinent facts to which a physician should be alerted:_____

In witness whereof, I have executed this Permission and Release Authorization this date:_____

PARENT/GUARDIAN or STUDENT NAME _____

SIGNATURE _____

ADDRESS, STATE, ZIP_____

HOME TELEPHONE_____

WORK TELEPHONE_____

INSURANCE NAME_____

GROUP/PLAN NO._____

INSURANCE CO. TELEPHONE_____

EMERGENCY CONTACT (name and phone)_____