PARTICIPANT
Image Release and Liability Waiver

PLEASE READ BEFORE SIGNING

In consideration of being allowed to participate on behalf of Society for disABILITIES' ("Society") programs and related events and activities, the undersigned acknowledges, appreciates, and agrees that:

1. Their likeness, or the likeness of their child/ward may be photographed or videotaped and that such image may be published in an outlet used to promote or publicize the program; and,
2. Participation includes possible exposure to and illness from infectious diseases including but not limited to COVID-19. While particular rules and personal discipline may reduce the risk, the risk of serious illness and death does exist; and,
3. I knowingly and freely assume all such risks, both known and unknown to me or are not foreseeable at this time, even if arising from the negligence or fault of the Released Parties, and assume full responsibility for my participation; and,
4. I hereby knowingly assume all the foregoing risks and accept personal responsibility for the damages following such injury, permanent disability or death; and,
5. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby release, indemnify, and hold harmless Society their directors, officers, employees, volunteers, agents, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, the owners and lessors of premises used to conduct the event ("Released Parties"), with respect to any and all illness, disability, death, or loss or damage to person or property, whether arising from the negligence or fault or conduct of any kind on the part of the Released Parties, to the fullest extent permissible under applicable law; and,
6. I agree that the staff and volunteers of Society may authorize emergency medical treatment for me, or for my child(ren), up to and including emergency hospitalization and surgery. I give the Society and volunteers the right to determine the appropriate medical facility/provider in the absence of a parent or caregiver. I agree to be personally responsible for any related medical expenses.

I HAVE CAREFULLY READ ALL PROVISIONS OF THIS RELEASE, WAIVER, AND ASSUMPTION OF RISK, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, HAVE NOT CHANGED IT ORALLY, AND SIGN IT FREELY AND VOLUNTARILY.

Participant Name: _____
(PLEASE PRINT CLEARLY)

Participant Signature: _____ Date: _____

Parent/Guardian Name*: _____
(PLEASE PRINT CLEARLY)

Parent Signature*: _____ Date: _____

***PARENT SIGNATURE REQUIRED IF PARTICIPANT IS UNDER 18 YEARS OF AGE OR IS UNABLE TO LEGALLY GIVE EFFECTIVE CONSENT.**

Please return this completed and signed form to Society for disABILITIES, 1129 8th Street, ste 101, Modesto, CA 95354
For more information or questions, please contact Channa
Phone: (209) 524-3536 | Fax: (209) 524-1205 | channa@societyfordisabilities.org