by

MT. WASHINGTON PEDIATRIC CHILDREN'S HOSPITAL AND THE ARC MONTGOMERY COUNTY:

Conditions of Participation Forms

Sibshops of Maryland is an interagency consortium involving Mt. Washington Pediatric Hospital, The Arc Montgomery County, Harford County Government Office of Disability Services, Mt. Zion United Methodist Church and their staff, volunteers and sponsors (hereafter referred to as "Sibshops Interagency Consortium"). In order for your child to participate in the Sibshops, all of the following forms must be completed in the entirety and returned to the Sibshops Coordinator on or before the first day of your child's attendance/ participation in the program.

ACKNOWLEDGMENT OF RISK AND WAIVER OF LIABILITY

Name of Parent/Guardian: _____

Child Participant's Name: _____

Child 's DOB: _____

Home Address:_____

City: _____State: _____ Zip: _____

Primary Phone #: _____Work Phone #: _____

I have chosen to allow my child to participate in the Sibshops Program at Mt. Washington Pediatric Hospital administered by the Sibshops Interagency Consortium. This Acknowledgment of Risk and Waiver of Liability form must be agreed to and signed as a condition of my child's participation in the Sibshops Program.

I understand that participating in the Sibshops Program is voluntary and my child's participation is my own personal decision. I understand that Sibshops Program activities include some physical exertion which may be strenuous and may cause physical injury to my child, and I am fully aware of the potential risks and hazards. I voluntarily and knowingly assume those risks for my child.

I understand that it is my responsibility to consult with my child's personal physician and/or have my child consult with a personal physician prior to and regarding any participation in the Sibshops Program. I hereby certify that my child is in proper physical health has no medical condition which would prevent participation in any Sibshops Program activities. In the event my child's personal physician concludes that my child has limitation to his/her participation in any

physical activities of the Sibshops Program, I hereby acknowledge and agree to obtain documentation from my child's personal physician of such conclusions and limitations and immediately provide this documentation to the Sibshops Interagency Team.

In consideration of my child being permitted to participate in the Sibshops Program, I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which I might incur, or which might occur to my child as a result of participation in this activity. In further consideration of being permitted to participate, I, on my behalf and on behalf of my child for myself, our heirs, executors, administrators, agents, and other personal representatives, irrevocably and unconditionally waive and release forever any and all manner of suits, actions, causes of action, damages and claims, known and unknown, that we may have against The Arc Montgomery County, Harford County Government Office of Disability Services, Mt. Zion United Methodist Church, Mt. Washington Pediatric Hospital, the University of Maryland Medical System Corporation, their affiliates, and their respective directors, officers, employees, agents and assigns arising from or in connection with my participation in this activity. Without limiting the generality of the foregoing in any way, I specifically understand that I am releasing and holding harmless for myself and my child, The Arc Montgomery County, Harford County Government Office of Disability Services, Mt. Zion United Methodist Church, Mt. Washington Pediatric Hospital, the University of Maryland Medical System Corporation and their affiliates and their respective directors, officers, employees, agents and assigns from financial liability for any economic harm, injury, bodily harm, or illness occurring during, arising from or relating to my and/or my child's participation in the Sibshops Program.

I understand that I will be wholly responsible for the welfare and safety of my child during any activity of the Sibshops Program.

The laws of the State of Maryland shall apply to this document.

I sign this document voluntarily with the intent to be legally bound by it. I have read this document and understand its contents.

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

PARENTAL AUTHORIZATION FOR USE OF PHOTOGRAPHSAND OTHER MATERIALS

I, _____, give my consent to the Sibshop Interagency Team to:
Parent/ Guardian Printed Name

Please Initial Below:

_____ Use my likeness or my child's likeness in ***print materials*** for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs (i.e.- photos in Newsletters or for Sibshops presentations, etc).

_____ Use my likeness or my child's likeness in ***television news stories or television commercials*** for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs.

_____ Use my child's ***artwork*** in print materials for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs.

_____ Use my child's ***likeness and/or artwork on the World Wide Web*** for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs.

_____ Provide my ***child's email and/or home address and phone number*** to all Sibshops participants

I understand that this release provides permission to use these images as described above, without restriction, indefinitely into the future.

Child Participant's Name: _____

Parent/Guardian Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I, _____, as the parent or guardian of
Parent/Guardian Printed Name

_____, a participant of the Sibshops Program, hereby grant
Child Participant's Name

permission to the Sibshops Interagency Team to secure, if necessary, emergency medical treatment for my child. I acknowledge that the Sibshops Interagency Team will make every effort to contact me, or any additional local emergency contacts that are named in the Child Participant's Medical Information Form, after securing emergency medical care, including calling 911, if necessary. This permission is granted for the Sibshops Program offered from **March 1, 2019 to March 1, 2020** ("Program Term") and will expire upon conclusion of the Program Term.

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

CHILD PARTICIPANT'S MEDICAL INFORMATION

Child Participant's Name: _____ Date of Birth: _____

Address _____

City: _____State: _____ Zip Code _____

Allergies (Include Food & Medications):_____

_____

Medications taken by child: _____

_____

Primary Doctor ***Name*: _____**

***Phone #*: _____**

Emergency Phone #: **_____**

Health Insurance ***Company/Policy Name*: _____**

***Phone*: _____**

***Member ID #*: _____**

Group #: **_____**

Mother's Name: **_____**

(and/or) ***Best Contact #*: _____**

Father's Name: **_____**

(and/or) ***Best Contact #*: _____**

Guardian's Name: **_____**

***Best Contact #*: _____**

Additional Emergency Contacts:

Name & Relation: **_____*Phone #*: _____**

Name & Relation: **_____*Phone #*: _____**