Medical Release Form
New England Cheer and Dance Competition
November 9, 2024

Liability Release: For good and valuable consideration, the receipt and sufficiency of which hereby acknowledged, I _____________________, am parent or legal guardian of _____________________, a minor (hereinafter "Participant"), or I, as the participant, have reached the legal age of 18 years. I hereby grant the permission necessary to allow the Participant to participate in the 2024 New England Cheer and Dance Competition (hereinafter "Release"). I, in my own behalf of the Participant, further agree to release and hold harmless New England Cheer and Dance Competition, The Reggie Lewis Track and Athletic Center, and all affiliated with the Release including directors, officers, representatives, members, agents, athletic trainers, and employees (hereinafter "Releases") from any and all liability, including negligence, and any claim judgment, loss, liability, costs and expenses (including without limitations, court or attorney's fees) arising or connected with the Release, including traveling to and from the site of the competition. I further expressly agree to indemnify and hold harmless the Release and Releases, the heirs, successors, assigns, executors, and administrators against loss from any further claims, demands, or actions that may be subsequently brought by Participant or by any other persons on the account of any damages of any character resulting to Participant in any way from the forgoing activities.

I understand that a qualified certified athletic trainer will be in attendance at the competition, and further agree to allow the certified athletic trainer to treat Participant of any and all injury(s) or illness(s) incurred prior to, during, and at the conclusion of the competition. I further agree that if, in the judgment of the athletic training staff, further treatment for any condition required, the Participant ( ) may ( ) may not be transported to Children's Hospital. If treatment other than Children's Hospital is desires, please specify preferred medical treatment center below.

Signature of Legal Guardian or Legal Aged Participant ________________________

Date ________________

Address ____

City ___________________ State___________ Zip Code _________________

Telephone (___) _____________________

Health Insurance Provider _______________________ Policy # __________________

Preferred Medical Center ____