OMEGA Gymnastics

Private Transportation and Medical Treatment Release Form

Revised and Effective 09/15/2021

Transportation Release

_____ (name of participant) has my permission to be transported to and/or from OMEGA Gymnastics by the OMEGA bus/van, a chartered vehicle, or another privately owned vehicle driven by an adult acting as an agent of OMEGA or emergency personnel.

I hereby release and discharge OMEGA Gymnastics, its officers, agents, and employees from any and all claims or liability for personal injury or property damage my child may suffer while traveling to and/or from OMEGA Gymnastics.

X _____ Date:_____
Signature of participant or Parent/Guardian, if under 18

Consent For Medical Treatment

In the event that my child is (or I am, if adult 18 and over) injured or becomes ill and requires the attention of a doctor, I consent to any reasonable medical treatment deemed necessary by a licensed physician. In the event treatment is called for, which a physician and/or hospital personnel refuse to administer without my consent, I hereby authorize OMEGA staff to give such consent for me if I cannot be reached by telephone at one of the numbers listed below or if, because of an emergency, there is not time or opportunity to make a telephone call. In the event it becomes necessary for OMEGA staff to give consent for me, I agree to hold OMEGA and its agents free and harmless of any claims, demands, or suits for damages arising from the giving of consent, so long as the treatment is administered by or under the supervision of a licensed physician. I also acknowledge that I will be ultimately responsible for the cost of any medical care, should the cost of that care not be covered or reimbursed by my health insurance carrier. I acknowledge it is my responsibility to advise OMEGA in writing of any allergies, medical problems or prescription medicine requirements that would be pertinent to the treatment of my child.

X _____ Date:_____
Signature of participant or Parent/Guardian, if under 18

Parent/Guardian Name: _____
Home Phone: _____ Cell Phone: _____

Please list any current medications or health conditions:

_____

_____

_____

Medical Insurance Company Name : _____
Group: _____ Plan/Policy: _____
Physician's Name: _____ Phone: _____