

Student's full name: _____

Address, City, State, Zip: _____

Phone numbers where parent/guardian can be reached on day of activity:

(____) ____ - _____ Home / Work / Cell (circle one) Who: _____

(____) ____ - _____ Home / Work / Cell (circle one) Who: _____

Student's medical information:

Allergies: Food (nuts, etc.): _____ Insects/Animals: _____

Other Allergies: _____

Medications being taken & how often: _____

Family doctor: _____ Doctor's phone :(____) ____ - _____

I, _____, parent or legal guardian of the above-mentioned student, hereby give permission for my son/daughter to participate in the Food for Thought Program (FFT) activity day on _____ (date). In consideration of the acceptance of my child's voluntary participation in FFT, I hereby waive, release and discharge any and all claims for damages for death, personal injury or property damage which I may have, or which hereafter accrue to me against Triskeles as a result of my child's participation in the above captioned **FFT**. This release is intended to discharge Triskeles, its officers, directors, employees, representatives and volunteers, partner organizations, and any all other private or public agencies involved in FFT from and against any and all liability arising out of or connected in any way with my child's participation in **FFT**.

It is further understood that accidents and injuries can arise out of participation in the **FFT**; knowing those risks exist, nevertheless, I hereby agree to assume those risks and to release and to hold harmless all persons or agencies mentioned above who (through negligence or carelessness) might otherwise be liable to my son/daughter (or his/her parents, guardians or their heirs or assigns) for damages.

Specific risks at worksite: Heat, sharp implements, tools, insects, allergic reactions, and other gardening, cooking and travel risks. When riding in Triskeles provided vehicles, all persons **MUST** wear their seatbelt!

I further agree that any Triskeles representative is authorized to obtain emergency medical treatment for my son/daughter, up to and including emergency hospitalization and surgery. I agree to be personally responsible for any related medical expenses.

Parent's/Guardian's Signature

Date

PRINTED Name of Above Parent or Guardian Giving Permission