

**WAIVER 2020**

For office use only  
Medical Notes  Registered



**USE FOR INDOOR  
FAMILY DROP IN PROGRAMS**

Phone: 604-933-6166 Fax: 604-933-6168 www.placemaillardville.ca 1200 Cartier Ave, Coquitlam BC, V3K 2C3

**PLACE MAILLARDVILLE COMMUNITY CENTRE  
FAMILY Drop In Programs Only**

**PARENT/GUARDIAN INFORMATION:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Male  Female

Phone Number: \_\_\_\_\_ Alternative Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_ Receive our monthly newsletter?  YES  NO

**PHOTO RELEASE:** To help us promote our programs and receive continued funding from our sponsors we require photos of our programs in action. Do you give permission to use program photos in promotional material?  YES  NO

Are there any medical conditions the instructor needs to be aware of:  YES  NO

If yes, please specify: \_\_\_\_\_

Are there any food allergies/restrictions: \_\_\_\_\_ EPI Pen required:  YES  NO

**CHILD(REN) INFORMATION**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthday: \_\_\_\_\_ (mmm/dd/yyyy)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthday: \_\_\_\_\_ (mmm/dd/yyyy)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthday: \_\_\_\_\_ (mmm/dd/yyyy)

**WAIVER SIGNATURE:**

**Note:** We will retain this waiver until the end of the calendar year. It will then be shredded. A new waiver must be completed at the beginning of every calendar year. It will be your responsibility to update the office with any changes to the above information.

I/We agree that I/my son/daughter will follow all reasonable instructions and directions of the program instructor(s) in connection with the operation of Place Maillardville.

I/We release, remise and forever discharge Place Maillardville staff, program instructor(s) and partners of Place Maillardville of and from all manner of actions, claims and demands of whatever nature which result from any accidental injury, loss of expense sustained, arising out of or in any way connected with participation in any Place Maillardville program or event.

In the event that I'm / my child (is) injured, ill or in need of medical attention and I/We are unable to be contacted. I/We authorize Place Maillardville staff, program instructor(s) and volunteers to seek medical attention on my/our behalf.

I agree that if I or any member of my household displays any symptoms of illness or is not feeling well, I/we will not attend a Place Maillardville program.

Signature (Parent/Guardian/Participant 16yrs of age or older)

Date