

WAIVER 2022

For office use only
Medical Notes Registered



What program(s) are you registering for:

Please send completed waiver
to info@placemaillardville.ca

Phone: 604-933-6166 Fax: 604-933-6168 www.placemaillardville.ca 1300 Rochester Ave., Coquitlam BC, V3K 2X5

**PLACE MAILLARDVILLE
FAMILY Programs Only**

PARENT/GUARDIAN INFORMATION:

First/Last Name: _____ Phone #: _____

First/Last Name: _____ Phone #: _____

Address: _____ City: _____ Postal Code: _____

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 for you or your child? YES NO

If yes, please specify: _____

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

CHILD(REN) INFORMATION

Name: _____ Gender: _____ Birthday: _____ (mmm/dd/yyyy)

Name: _____ Gender: _____ Birthday: _____ (mmm/dd/yyyy)

Name: _____ Gender: _____ 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 Société Place Maillardville Society staff, program instructor(s) and partners of Société Place Maillardville Society 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