I (We), the undersigned, hereby give my(our) permission for my(our) child

____

(Child's full name)

to participate in the activities of the Autism Project from the date appearing under my(our) signature(s) up through and including August 2012. In the event of illness or accident during an activity, I request that measures be instituted without delay as judgment of medical personnel dictates. I hereby give permission to the physician selected by the adult agent to hospitalize, secure proper anesthesia, to order injection or surgery, or otherwise to give medical care to my child. I request that I be notified about medical care being given to my child, but do not make it a precondition to the administration of said medical care. I expressly waive all claims against, and hold harmless and/or indemnify The Autism Project Inc. and their representatives for any accident, injury, loss, or damage that may occur in conjunction with activities and trips.

>>

MEDICAL INSURANCE INFORMATION ***(Please* PRINT*)***

Mother's Name: ________________________________**Father's Name:**__________________________

Mother's Address: ____

Father's Address:____

Insurance Company: ____

Certificate/Policy Number:____

Mother's Home phone:_____________________ **Father's home phone:**_________________________

Father's work phone:______________________ **Father's cell phone:**___________________________

Mother's work phone:_____________________ **Mother's cell phone:**__________________________

____

Please State Any Known Medical Conditions

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Medications

I have read all of the foregoing, completed all the blanks above, understanding everything herein set out, and expressly consent to all matters set forth above.

_________________________ _________________________

Parent or Legal Guardian Signature *DATE*