



# OHIO HIGH SCHOOL CHEER COACHES ASSOCIATION RELEASE/WAIVER FORM



Release and Waiver Form:

Participant's Name	Name of Parent/Legal Guardian	School/Group Name
Address		
City	State	Zip
(____) _____ Home Phone	(____) _____ Work Phone/Cell Phone	(____) _____ School Phone

I \_\_\_\_\_, as a parent or legal guardian of \_\_\_\_\_, a minor (hereinafter "Minor"), hereby grant the permission necessary to allow the Minor to participate in the above noted event to be contracted by the Minor's High School. I acknowledge and agree, on my own behalf and on the behalf of the Minor, that such participation subjects the Minor to the possibility of physical illness or injury (minimal, serious, catastrophic and/or death) and that I, on my own behalf and on behalf of the Minor, acknowledge that the Minor is assuming the risk of such illness or injury by participating in the above OHSCCA contracted event. In the event of such illness or injury, I authorize the Minor's cheerleading coach to obtain necessary medical treatment for the Minor and hereby, on my own behalf and on the behalf of the Minor, release and hold harmless OHSCCA, its affiliates, and the respective owners, directors, staff, members, and employees of OHSCCA, (hereinafter collectively "Releasees") in the exercise of this authority. I further acknowledge and understand that I will be responsible for any and all medical and related bills that may be incurred on behalf of the Minor for any illness or injury that the Minor may sustain during the above noted OHSCCA contracted event and while traveling to and from the site for the above noted OHSCCA contracted event whether or not the OHSCCA event actually occurs. I understand that OHSCCA may produce promotional materials relating to its programs. I understand that as a participant in and/ or spectator of the above noted OHSCCA contracted event the Minor may be included in videotapes or photographs taken during the above noted OHSCCA contracted event. Therefore, without reservation or limitation, I, on my own behalf and on the behalf of the Minor, hereby assign, transfer and grant to OHSCCA, its successors, assignees, licensees, sponsors, any television networks and all other commercial exhibitors the exclusive right to photograph and/or videotape the Minor and to utilize such videotapes and photographs and Minor's name, face, likeness, voice and appearance as part of the above noted OHSCCA contracted event, in advertising and promoting the above noted OHSCCA contracted event or in advertising and promoting similar future events, including on OHSCCA social media sites. I further understand that neither OHSCCA nor any third party is under any obligation to exercise any of the foregoing rights, licenses and privileges. I, on my own behalf and on the behalf of the Minor, hereby warrant that I have read this Release and Waiver in its entirety and fully understand its contents. I, on my own behalf and on the behalf of the Minor, am aware that this Release and Waiver releases Releasees from liability and contains an acknowledgment of my voluntary and knowing assumption of the risk of injury or illness. I, on my own behalf and on the behalf of the Minor, further acknowledge that nothing in this Release and Waiver constitutes a guarantee that the above noted OHSCCA contracted event will occur. I, on my own behalf and on the behalf of the Minor, have signed this document voluntarily and of my own free will.

Signature of Parent or Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Minor: \_\_\_\_\_



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Minor's Birth Date: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Doctor's Phone #: (\_\_\_\_) \_\_\_\_\_

Dentist's Name: \_\_\_\_\_

Dentist's Phone #: (\_\_\_\_) \_\_\_\_\_

In regard to the above mentioned person, check all that apply, provide explanation on back of form if needed.

Allergies to foods, medication, etc.

High Blood Pressure

Conditions currently under treatment

Asthma

Convulsions

Medications currently taking

Diabetes

Epilepsy

Migraine Headaches

Heart Trouble

Fainting Spells

Pre-existing injury under treatment

Contact Lenses

Other \_\_\_\_\_

Daily Medication and Schedule:  
\_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Please Check One:

School Insurance

Participant's Family's Insurance

Primary Insured's Name \_\_\_\_\_