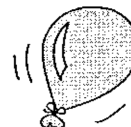
du Ballon Rouge

Tourette Syndrome Association of Texas



PARTICIPATION CONSENT

I understand and certify that my child, ______________________, may participate in du Ballon Rouge and its activities at Camp for All, and that his/her participation is completely voluntary. I have familiarized myself with the programs and activities at du Ballon Rouge in which my child will participate. I recognize that certain hazards and dangers are inherent in these activities, which may include, but not be limited to, the activities of horseback riding, high and low elements rope course, swimming, archery, canoeing and team sports such as soccer. I acknowledge that although the Tourette Syndrome Association of Texas and du Ballon Rouge have taken safety measures to minimize the risk of injury to program participants, the Tourette Syndrome Association of Texas and du Ballon Rouge cannot insure or guarantee that the participants, equipment, premises or activities will be free of hazards, accidents or injuries. I understand that under Texas Law, an equine professional is not liable for an injury or death of a participant in equine activities resulting from the inherent risks of equine activities. I recognize and have instructed my child in the importance of knowing and abiding by the rules, regulations and procedures for du Ballon Rouge. I have received approval from a doctor authorizing my child to participate in du Ballon Rouge and its activities at du Ballon Rouge.

______________________________ ______________

Parent or Guardian (Father) Date

______________________________ ______________

Parent or Guardian (Mother) Date

PERMISSION FOR TREATMENT

The health history described in the du Ballon Rouge Child's Program Information and Health History Form is correct to the best of my knowledge. In the event of an accident or injury involving my child, ______________________, I authorize the du Ballon Rouge and/or du Ballon Rouge directors, counselors, medical staff, volunteers or other executors to obtain medical treatment for my child. I give permission to the physician selected by the program director to order x-rays, routine tests, and treatments; and, in the event of any perceived emergency, I give permission to the physician selected by the program director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child named above. I understand that payment of any medical expenses incurred by my child will be my responsibility.

The following is medical insurance coverage for my dependent. I understand that no health insurance will be provided by the Tourette Syndrome Association of Texas.

If Medicaid, indicate number:______________________________

Name of Insurance Company:______________________________

Policy Number:______________________ Group Number:______________________

Name of Insured or Holder:______________________________

______________________________ ______________

Parent or Guardian (Father) Date

______________________________ ______________

Parent or Guardian (Mother) Date