Medical Release and Liability Form

Blooming Pediatric Therapies, Inc.
445 Park Ave. Suites A&B
Cary, IL0013
ph: 847.791.5517 fax: 224.333.6706
(Please do not alter this form)

Name of Participant_____ Name of Legal Guardian/s_____

Address, City, State, Zip_____

Home Phone (_____) _____ Work/Cell Phone (_____) _____

Age _____ Birthday _____ E-mail_____

Functions and Activities
I understand that participating in Blooming Pediatric Therapies therapy and activities is by Parent/Guardians choice. Prior to participation in such activities, I acknowledge that there are certain risks associated with these activities, including, by way of example, physical injury due to activity-related accidents, physical injury. In addition, I acknowledge that there may be other risks inherent in these activities of which I may not be presently aware.

Release of Liability
By signing this Permission and Waiver Form as the Parent/Guardian, I expressly warrant that this child, named above as a participant, is capable of withstanding both the physical and mental demands of these activities. I also expressly assume all risks to the child or me participating in the activities, whether such risks are known or unknown to me at this time. I further release Blooming Pediatric Therapies and its employees, contractors and volunteers from any claim that my child may have or that I may have against them as a result of injury or illness incurred during the course of participation in these activities. This release of liability is also intended to cover all claims that members of the child's or my family or estate, heirs, representatives or assigns may have against Blooming Pediatric Therapies, and its employees, contractors and volunteers. I further agree to indemnify and hold harmless Blooming Pediatric Therapies, and its employees, contractors and volunteers from any and all claims arising from my participation in its activities and programs, or as a result of injury or illness of my child during such activities.

First Aid and Emergency Medical Treatment
I recognize that there may be occasions where the child named above or I, if I am a participant, may be in need of first aid or emergency medical treatment as a result of an accident, illness, or other health condition or injury. I do hereby give permission for agents of Blooming Pediatric Therapies to seek and secure any needed medical attention or treatment for any participants, if in the agent's opinion such need arises. In doing so; Parent or Guardian agrees to pay all fees and costs arising from this action to obtain medical treatment. I give permission for attending physician(s) and other medical personnel to administer any needed medical treatment, including surgery and, again, I agree to pay for the medical treatment.

Emergency Contacts
Doctor_____ Phone Number _____

Name#1_____ Relation _____Phone_____

Medical History
(Include special medical needs or concerns such as asthma, allergies, dietary needs, medications, any recurring medical conditions and other Information that therapist should know about the participant)

_____
_____
_____

For use if the Participant is a Minor
I represent that I am the parent/guardian of the child listed above, who is under 18 years of age. I have read the above Permission and Waiver Form and am fully familiar with the contents thereof. I give permission for the child named above to participate in the activities of Blooming Pediatric Therapies, Inc. I hereby consent to the Permission and Waiver Form, including the Release of Liability above, on behalf of the child, and agree that this Permission and Waiver Form shall be binding upon me and my estate.

Signature of Parent or Legal Guardian_____ Date _____

Print Name of Parent or Legal Guardian _____