

**Declaration of Consent**

*Please indicate your consent to each item by signing below each statement.*

**Emergency Medical Treatment Consent**

1. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_give

permission to the medical personnel selected by SOAR Special Needs to order hospitalization, treatment, anesthesia, and surgery if necessary in case of an emergency when parents cannot be reached.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Photograph Release Consent**

1. I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_give SOAR Special Needs permission to use my child’s name and/or picture in presentations, media releases, newsletters and marketing materials solely for the purpose of promoting the SOAR special needs ministry.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Waiver of Liability Consent**

1. I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent/guardian of\_\_\_\_\_\_\_\_\_\_\_\_\_\_agree to release SOAR Special Needs and all staff and volunteers from all liability for any additional illness or injury to my child, and for any accidental damage or destruction of my child’s property during the provision of respite care services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

*Thank you for your cooperation. If you have any questions, please contact Stephen J. Hunsley, M.D., SOAR Ministry Director, 816-506-1305.*

*doc@soarspecialneeds.org**.*