



Release – Permission to Treat & Emergency Information

AS CUSTODIAL PARENT OR COURT-APPOINTED GUARDIAN OF _____ (hereinafter referred to as "CHILD"), I DO FOR BOTH OF CHILD'S PARENTS, FOR CHILD AND CHILD'S HEIRS AND SUCCESSORS, RELEASE INSTINCT VBC, & SPORI SUPPORT LLC AND ANY OF ITS AGENTS OR REPRESENTATIVES (ALL OF THE FOREGOING COLLECTIVELY REFERRED TO AS "SPORI SUPPORT LLC.") FROM ALL CLAIMS, LIABILITIES AND DAMAGES ARISING OUT OF OR IN CONNECTION WITH THE ABOVE MENTIONED CHILD'S PARTICIPATION IN ANY INSTINCT VBC & SPORI SUPPORT LLC PROGRAM. I PROVIDE THIS RELEASE BECAUSE I UNDERSTAND THAT ATHLETICS, PHYSICAL TRAINING AND COMPETITION CAN BE A DANGEROUS UNDER TAKING REGARDLESS OF HOW CAREFUL OR PRUDENT ANY PERSON, FIRM OR FACILITY MIGHT BE. _____ (initials)

I also confirm that I have been advised by Instinct VBC & Sport Support LLC of the risks associated with the program. It was seriously recommended that the "CHILD" should consult a physician before engaging in any activities associated with instinct VBC & Sport Support LLC. _____ (initials)

Further, I give permission to Instinct VBC/Sport Support LLC to treat "CHILD" or arrange for medical care or treatment for "CHILD" in any situation deemed reasonably necessary by Instinct VBC & Sport Support LLC. If circumstances permit, Instinct VBC & Sport Support LLC shall attempt to communicate first via telephone with the following emergency contacts for "CHILD".

Primary Emergency Contact:

Name	Relationship	Telephone Number

In the event neither emergency contact can be reached or if the urgency of the situation requires immediate attention without prior telephone contact, INSTINCT VBC & SPORI SUPPORT LLC may arrange for medical treatment for the "CHILD" at the expense of the parent or guardian signing this form. Health Insurance, PPO information for child is as follows:

Insurance Company: _____ Policy Number: _____

Address: _____ City: _____ St: _____ Zip: _____

Telephone: (____) _____

In order to seek appropriate medical care of treatment of Child, please disclose the following:

Allergies: _____ (please specify, enter "none")

Heart disease or other: _____ (please specify, enter "none")

Any other conditions, symptoms or disability which would or might affect medical care or treatment or participation in the INSTINCT VBC & SPORI SUPPORT LLC program:

Signature (Custodial parent or court appt. guardian)

Date

Name: _____