Release Form

RELEASE OF INDIVIDUAL FROM HOLLEY FAMILY VILLAGE AT DESALES CENTER

Authorization is granted for the release of (child's name) _____ to: employees, and staff of Holley Family Village, Brooklyn, Michigan. In addition, only those individuals listed below are authorized to remove the individual from summer programs during their stay.

Name: _____Relationship: _____

Name: _____Relationship: _____

The following authorization is required by the Michigan Department of Social Services pursuant to PA 116 of 1973 and administrative rule 127.(1). The health history contained herein is correct, so far as I know, and the person herein described has permission to engage in all prescribed activities expect as noted by me and/or the physician. In the event I cannot be reach in an emergency, I hereby give permission to the physician selected by a designated representative of the Holley Family Village at the De Sales Center to authorize emergency medical or surgical treatment, routine, nonsurgical medical care, hospitalize, secure proper anesthesia, or to order injections(s) for my child. The person herein describe is in good health, has all required immunization current, and I assume the health responsibility for the individual:

RELEASE OF LIABILITY

I acknowledge that my child _____ while at Holley Family Village at De Sales Center will be involved in camp type activities such as, but not limited to: swimming, boating, arts, crafts, various games and other outdoor activities. I am also aware that while at Holley Family Village at De Sales Center my child will be sleeping in a bunk bed. I understand that there are inherent risks associated with theses activities and by signing below I, on behalf of my family and any other interested parties, agree to release and discharge De Sales Center, The Holley Institute, St. John Hospital and Medical Center, St. John Providence Health System, and their agents, employees, and volunteers from all claims for damages, costs, expenses, losses, in any manner related to personal injuries of any kind whatsoever, including death.

REAUTHORIZATION AND WAIVER FOR TAKING AND PRESENTING IMAGES OF AND/OR INFORMATION FROM/ABOUT A PERSON AT ST. JOHN PROVIDENCE HEALTH SYSTEM

I, the undersigned, do hereby authorize a representative of St. John Providence Health System, print media (newspaper, magazine, etc.) or electronic media (television, radio, etc.) to photograph, film, audio, or video tape and/or interview my child for possible presentation in public.

Date: _____Signature: _____ Print Name: _____

Parent or Guardian Parent or Guardian