



**York County Pageants**

**ACCIDENT RELEASE**

ALL OF OUR PAGEANT STAFF WILL BE TAKING EVERY PRECAUTION TO PREVENT IT, BUT THE POSSIBILITY EXISTS IN ANY COMPETITION OR ACTIVITY THAT AN ACCIDENT REQUIRING MEDICAL ATTENTION COULD OCCUR. THEREFORE, THE FOLLOWING IS TO BE SIGNED BY EACH CONTESTANT AND/OR PARENT.

I/We will be responsible for all medical expenses for treatment (for the full year, if you are selected as the representative) required (but not limited to) any accident resulting from competing in all events leading up to and including the York County Scholarship Competition. I also grant permission to be transported to the nearest hospital should medical attention be necessary.

I/we do hereby agree to indemnify and hold harmless, release and discharge York County Scholarship Organization, its agents, servants, volunteers, from any and all claims for personal injuries or property damage occurring to or sustained by the contestant while participating in pageant activities or in the act of being transported to and from said activity and including any and all consequential damage claims which I/we may be entitled to without regard to the negligence of the parties. I agree to follow the rules and regulations set by York County Scholarship Pageants representatives whether written or verbal. This agreement has been entered into freely, voluntarily and after a full opportunity for review by the undersigned.

**Contestant's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**MEDICAL RELEASE INFORMATION**

Parent/Guardian phone # \_\_\_\_\_

Physician to be called in case of emergency \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Phone # \_\_\_\_\_

Medical information that may affect activities: (special dietary concerns, medications, conditions, etc.)

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

In my absence should the need arise while she is participating in programs of the MYCSO, I hereby authorize, consent and direct the MYCSO, Inc., its directors and officers and any physician, hospital or other health care provider selected by the Organization to take such action as is necessary in the circumstances to provide emergency care and related treatment of the above named. I hereby designate the MYCSO, Inc. its directors and officers my authorized agent for the signing of consent forms required by such health care providers in connection with such health care.

Health Insurance ID number \_\_\_\_\_ Group # \_\_\_\_\_ Plan # \_\_\_\_\_

Name of health care insurance provider: \_\_\_\_\_

**DATE** \_\_\_\_\_ **Signature of Parent/Guardian** \_\_\_\_\_

**DATE** \_\_\_\_\_ **Signature of Contestant** \_\_\_\_\_