

JOHN HEINZ INSTITUTE
RECREATIONAL THERAPY DEPARTMENT
AUTISM OPEN SWIM PROGRAM

I. GENERAL INFORMATION

Name of Child: _____ Age: _____

Name of Parent/Guardian: _____

Address: _____

Phone: _____ Work Phone: _____

II. PARTICIPANT RELEASE

During my child's participation in the Autism Open Swim program at the John Heinz Institute, I understand and agree that neither the John Heinz Institute of Rehabilitation Medicine, nor their officers, directors, employees, agents, members or volunteers, shall assume or have any responsibility or liability for expenses or medical treatment or for compensation from any injury I or my child may suffer during or resulting from my participation in this program. I do hereby, for myself, my heirs, executors and administrators, waive, release, and forever discharge any and all rights and claims for damages and I may hereafter accrue to me or my child arising out of, or in any way connected with my participation in this program.

I also represent and warrant that I have been advised to seek consultation from my child's doctor about whether my child and I can safely participate in this program and whether there are any precautions or limitations to my or my child's participation.

Signature of Parent/Guardian

Date