



WAIVER OF LIABILITY AND ASSUMPTION OF RISK

Parent/Guardian Name _____ (please print)

Child's Name _____ Age _____ (please print)

The mission of Autism Academy of South Carolina (AASC) LINKED social skills classes is to increase social skills, physical activity, and overall quality of life in youth with social skills deficits including but not limited to ADHD, autism, learning disabilities, and other developmental disorders. Clients will participate in social skills, physical activity, nutrition, and life skills activities. Autism Academy of South Carolina has undergraduate and graduate students running the sessions of group under the supervision of a licensed clinical psychologist. The students will facilitate the classes and have primary contact with participants. All volunteers must pass a criminal background check prior to leading classes and receive volunteer training.

In Social Skills Groups, AASC not provide the following services during the skills program sessions: individual or family therapy; medication or medication management; and crisis intervention. If your child requires medication or medication management during the sessions, you will have to make separate arrangements for this to occur. Also, behavior crises may force The Autism Academy of SC to remove the child from the group processes and even the skills program sessions if the child's behavior becomes disruptive or creates safety risks.

To participate in the Social Skills Groups, the parent(s), or guardian(s) of each child (participant) must submit a completed copy of this waiver, assumption of risk of all claims each may have, and the accompanying health, emergency contact and limited power of attorney in case of emergency form. I have agreed to allow my child/ward to participate in Social Skills Groups and affirm that my decision and my child/ward's participation are voluntary based upon my own evaluation of the appropriateness of the Social Skills Groups program for my child/ward and my child/ward's appropriateness for the Social Skills Groups.

WAIVER. In consideration for AASC accepting my child to participate in the Social Skills Groups, I, _____, for myself; my child/ward _____; and my heirs, personal representatives or assigns, do hereby waive, release, and hold harmless AASC, its owners, management, staff/externs, and contractors (herein after "AASC") from all claims of any kind that rise out of my child's participation in the Social Skills Groups program. I hereby discharge AASC from all liability stemming from our participation in the Social Skills Groups, and covenant not to sue AASC for all such claims.

ASSUMPTION OF RISK: Participation in Social Skills Groups setting including both group skills training sessions, and physical activity inevitably carries with them certain inherent risks that cannot be eliminated regardless of the safety precautions and care taken to avoid injuries. The specific risks vary from one activity to another, but the risks inherent in Social Skills Groups activities range from 1) minor

injuries such as scratches, bruises, and sprains; (2) major injuries such as eye injury or loss of sight, joint or back injuries, heart attacks, and concussions; to (3) catastrophic injuries including paralysis and death. I have read the Social Skills Groups literature, evaluated its appropriateness for my child/ward, and acknowledge that I have had access to AASC to ask any questions and resolve any concerns. I know, understand, and appreciate these inherent risks and assume sole, exclusive, and full responsibility for my child/ward's injury or harm any manner related to Social Skills Groups and its activities. To minimize risk, I have instructed my child/ward to obey all Social Skills Groups rules, instructions, and staff directions to the best of his/her ability.

INDEMNIFICATION AND HOLD HARMLESS: I also agree to indemnify and hold harmless The Autism Academy of SC from any and all claims, actions, results, procedures, costs, expenses, damages and liabilities, including attorney's fees brought by myself, my child/ward, their representative, or any other person or third party as a result of my child/ward's participation in Social Skills Groups program and to reimburse them for any such expenses, costs, and damages incurred.

SEVERABILITY: The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is intended to be as broad and inclusive as is permitted by the law of the State of South Carolina and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

ACKNOWLEDGEMENT OF UNDERSTANDING: I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, and understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing the agreement freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

MEDICAL: I understand that I should obtain health insurance for my child/ward coverage prior to participating in Social Skills Groups. I further understand that I am solely responsible for my child/ward's medical expenses. I attest that my child/ward is in good physical health and I have disclosed on the written application any limitations to safe participation in Social Skills Groups for my child/ward including all conditions that require accommodation and medication. I understand that the Social Skills Groups will not administer medications and that I am solely responsible for insuring that my child/ward is properly receiving his/her medication at all times during Social Skills Groups.

EMERGENCY TREATMENT: I hereby give my permission that the Autism Academy of South Carolina team is authorized to give my child reasonable first aid, or if my child should require emergency medical or surgical treatment, he/she may be treated at the nearest emergency facility by the physician in attendance and any other health care professionals to consult. I hereby authorize the Releasees and their authorized representatives to disclose any of my health-related information to any healthcare provider and I consent to the admission of the participant to the hospital, the administration and performance of all examinations and the administering of medicine, treatment, anesthetics, operations, x-rays or other procedures which the physicians attending the participant deem necessary for the emergency care and treatment of the participant. I hereby agree to accept responsibility for any financial indebtedness occurring in transport, in the emergency room, or clinic treatment of the participant at the emergency facility utilized. Further, I understand that, upon my arrival at the hospital, I will authorize continued medical care.

I hereby and forever release and discharge the Releasees (defined below) from any and all claim or liability arising out of or resulting from (i) any first aid, use or administration of an injection or other medical procedures, or related action or inaction rendered by a Releasee or (ii) a decision by any Releasee or any agent or representative of a Releasee to exercise the power to consent to medical or dental treatment that has been granted and authorized by me herein.

I also understand that it is my responsibility to notify the Autism Academy of South Carolina team if my child contracts a contagious illness (including, but not limited to, pink eye, chicken pox, whooping cough, fever). Further, there are no health-related reasons or problems that would restrict my child from participating in Autism Academy of South Carolina other than the following:

ALLERGY NOTIFICATION:

Please list any allergies and dietary restrictions for your child:

Need Epi-Pen? ___ YES ___ NO

Emergency Contact 1: _____ Primary Phone: _____

Emergency Contact 2: _____ Primary Phone: _____

Other adults permitted to pick up your child:

1. _____ 2. _____
Print Name Clearly Print Name Clearly

PHOTO RELEASE: I give permission for photographs taken of me/my child/ward while participating in Social Skills Groups to be used in marketing/public relations material in the promotion of Camp. _____ Initial

NOTICE OF PRIVACY PRACTICES: By signing this form, I am also acknowledging I have read/received a copy of the Autism Academy of SC's Notice of Privacy Practices Policy (see attached). Please retain a copy of our Privacy Policy for your file. _____ Initial

By signing below, I acknowledge that I have read, understand this waiver of liability, assumption of risk, and agree to its terms.

(of Parent/Guardian if minor) _____ Signature
Date

Print parent/guardian name