



**Shape Up Walking Challenge  
Parent/ Guardian Permission Form**

**\*\*In order for your child to participate in the Shape Up SF Walking Challenge, your permission is required. Please complete the front and back of this form and return by [Date] \_\_\_\_\_.**

I, [parent/guardian name] \_\_\_\_\_, am the parent and/or legal guardian of [child's name] \_\_\_\_\_, and acknowledge that [Program name] \_\_\_\_\_ is organizing a walking group for the Shape Up SF Walking Challenge from March 1 to May 7, 2010.

[Child's name] \_\_\_\_\_ has my permission to participate in the Shape Up SF Walking Challenge and related activities. Employees of [Program name] \_\_\_\_\_ are hereby given the following authority during the dates indicated above.

In the event of an emergency, employees may give consent to medical treatment (illness or accident) that may be immediately required by [child's name] \_\_\_\_\_ in the absence of the parent or guardian. Employees of [Program name] \_\_\_\_\_ are hereby released from liability for all actions taken in good faith during the Shape Up Walking Challenge program.

**Media Release** (Please check appropriate box)

You have my permission to use images of my child for the Shape Up SF Walking Challenge media endorsements such as website, newspaper, or television, photo albums.  
Child Name: \_\_\_\_\_

You **do not** have my permission to use images of my child for the Mayor's Challenge Shape Up San Francisco media endorsements such as website, newspaper, or television, photo albums.

\_\_\_\_\_  
**Signature of parent or guardian**

\_\_\_\_\_  
**Date**

**Emergency Contact and Medical Information** – A health care provider requires a parent or guardian’s permission prior to treatment. In the unlikely event that your child sustains an injury or illness during the Shape Up Walking Challenge we would like to ensure prompt treatment. Please provide your child’s medical information below and sign indicating if you wish us to attempt to contact you prior to providing medical care.

**Emergency Information**

Participant’s Name: \_\_\_\_\_

Address: \_\_\_\_\_

**Health Conditions/ Allergies** (please list): \_\_\_\_\_

**Medications:** (please list): \_\_\_\_\_

Is the participant covered by medical insurance?  Yes  No

Health Insurance \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Name and phone number of child’s general physician: \_\_\_\_\_

Hospital Preference \_\_\_\_\_

I hereby give my permission for any medical treatment needed for my child in response to an injury, illness or medical condition arising while participating in the Shape Up Walking Challenge.

**Authorized Signature(s):**

**Parent/ Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone& ext: \_\_\_\_\_ Pager/Cell Phone: \_\_\_\_\_

**Alternative Emergency Contact:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone &ext: \_\_\_\_\_ Pager/ Cell Phone: \_\_\_\_\_

Please attempt to call me prior to the provision of medical care.