# Texas State Squires Circle

## Release of Claims, Indemnification Agreement and Medical Authorization

I, the parent/guardian of ________________________ ("MY SON") want MY SON to participate in the various programs and activities of the Texas State Squires Circle and specifically want MY SON to attend the **State Convention** ("THE PROGRAM"). I realize that, while traveling or attending THE PROGRAM, there is a possibility that MY SON could be injured. I hereby acknowledge that the Texas State Squires Circle, by allowing MY SON to participate in THE PROGRAM is good, valuable and sufficient consideration for me entering into the legally binding agreement contained herein. Further, I acknowledge that the Texas State Squires Circle and the other parties being released are relying on my agreement contained herein as the basis for allowing MY SON to participate in THE PROGRAM.

For said consideration, I hereby release and discharge Texas State Council, Texas State Circle, the Knights of Columbus Council sponsoring THE PROGRAM, their agents, servants, employees and volunteers, including but not limited to, the advisors and sponsors, and all parents and individuals participating in THE PROGRAM and the Squires Circle, of and from any and all claims, demands, causes of action and expenses arising out of or in any way connected with MY SON participating in or attending THE PROGRAM. Further, for the same consideration, I hereby agree to indemnify and hold harmless Texas State Council, Texas State Circle, the local Squire Circle, their agents, servants, employees and volunteers, including but not limited to, the advisors and sponsors of the Knights of Columbus Council that sponsor the local Squire Circle, and all parents, individuals participating in and attending THE PROGRAM, of and from any and all claims, demands, causes of action and expenses arising out of in any way connected with any injury or damages sustained by MY SON's other parent, myself, or MY SON arising out of or in any connected with attendance in THE PROGRAM.

During THE PROGRAM, I can be reached at ____________________. My telephone number is ____________________. If I cannot be reached, please contact ____________________ at _______________, who has my full authority to authorize any medical treatment for MY SON. My medical insurance is with _______________, policy number _______________. MY SON's physician is ____________________ and his/her telephone number is _______________. MY SON is in good physical condition and does not have any illness or medical condition that requires special attention or that would in any way limit his ability to fully participate in THE PROGRAM.

I hereby request and consent to MY SON being permitted to participate in THE PROGRAM,

_________________________
MY SON's NAME

_________________________ _______________
Parent / Guardian's Signature Date