San Francisco Police Activities League

350 Amber Dr., SF, CA 94131 / 415.401.4666

SFPAL Liability Form

Sport:	**Team Name:**		**Division:**
Last Name:	**First Name:**	**Init.:**	**DOB:**
Address:	**City:**	**State:**	**Zip:**
Phone:	**School:**		**Grade:**
Parent/Guardian 1 Name:	**Email:**		
Home Ph:	**Cell Ph:**	**Work Ph.:**	
Address:			
Parent/Guardian 2 Name:	**Email:**		
Home Ph:	**Cell Ph:**	**Work Ph.:**	
Address:			
Alternative Emergency Contact (NOT listed above):	**Ph:**		
Insurance Company of Youth Participant:	**Policy #:**		

Existing medical condition/medications *(SFPAL requires a PAL Medical Clearance Form signed by a doctor—when existing conditions/medications are listed)*

In order for SFPAL to apply for foundation and individual support to underwrite our programs and keep costs at a minimum, we ask that you please respond to the following demographic information. *(This information is optional and confidential—we appreciate your assistance.)*

- Ethnicity of Youth: (please circle all that may apply or write in your response).

  African American Asian Latino/a Multi-Ethnic Other Non-White Pacific Islander Native/American Indian White Other: ______________________________

- Income Level (Please circle your annual household income):

  Less than $30,000 $30, 001-$40,000 $40,001-$55,000 $55,001-$75,000 over $75,001

Consent to Rules and Regulations

I, the parent/guardian of ______________________________ agree that the participant and I will abide by the rules of the SFPAL, its affiliates and sponsors. I herby release, discharge and/or otherwise indemnify the SFPAL, the San Francisco Police Department, the City and County of San Francisco, its affiliated organizations and sponsors, their employees and associated personnel against any claim by or on behalf of the participants as a result of participation in the program and/or being transported to or from the same, which transportation I hereby authorize. I also give permission for SFPAL to utilize any photographs taken of said child while participating in SFPAL activities for publicity and media purposes.

Name (please print): ______________________________

Parent/Legal Guardian—Please Print

Signature: ______________________________ **Date:** ____________________

Consent of Medical Treatment

As the parent/legal guardian of the above named participant, I herby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care my be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependent.

______________________________ ____________________

Signature of Parent/Guardian **Date**