Personal Information, General Liability & Medical Release Authorization

Required for all Weare Home Educators related activities during the 2024-25 Academic Year

Parent's Name:	Home Phone:
Address:	Cell Phone:
	Email:

General Liability Release

The undersigned hereby release, waive, discharge, and covenant not to sue Weare Home Educators (hereinafter "WHE"), Congregational Church of Goffstown or any of their directors, officers, employees, representatives, or volunteers, and owners of premises used to conduct the event from any and all potential actions, claims, demands, suits, judgments, liabilities, and proceedings both at law and in equity arising from and as more particularly related to any personal injury or damage to the property or person of the child(ren) named below, the undersigned parent(s), or legal guardian, resulting directly or indirectly from such child's or undersigned's participation in any WHE sponsored classes or activities.

The undersigned parent/guardian has the right to inspect the facilities and equipment to be used, and if the parent/guardian believes anything is unsafe, he or she should immediately advise teacher or directors of such condition(s) and refuse to participate.

Further, the undersigned acknowledge and fully understand that each participant will be engaging in activities that may involve risks that are not known or reasonably foreseeable at this time. The undersigned assume all the foregoing risks and accept personal responsibility for any damages, including personal injury.

The undersigned parent, or legal guardian, is fully responsible for any damage to the Congregational Church of Goffstown property, its contents, or another person on the property caused by any child named below.

Please Note: If you have any questions regarding the legal implications in signing this form, please be certain to consult with an attorney prior to signing.

Signature	**Date**

Coop Payment/Refund Policy

- A non-refundable deposit to secure enrollment in the WHE 2024-25 Coop Classes is due **July 30th**.
- Final payments must be made by **August 15th**.
- Payments may be mailed to: Weare Home Educators, P.O. Box 160, Weare, NH 03281
- If you want to cancel enrollment:
  - A refund of funds paid minus the non-refundable deposit will be given up to **August 15th**
  - No refunds will be given beyond August 31st.
  - In the event that WHE must cancel classes before September, due to unforeseen circumstances, a full refund will be given.

=>I have read and understand the WHE Payment/Refund Policy (*initial here)*_____

=>I have read, understand and will adhere to the WHE Policies 2024-25 Manual (*initial here)*_____

located on our site under Co-op Classes

Emergency Medical Release Authorization

I hereby give permission for any necessary medical attention to be administered to any child listed below in the event of an accident, injury, sickness etc. that might occur during any WHE activity until such a time as I may be contacted. I also assume responsibility for payment of such treatment.

Please Note: If you have any questions regarding the legal implications in signing this form, please be certain to consult with an attorney prior to signing.

Signature **Date**

Child's Name:	Child's Name:
DOB:	DOB:
Primary Care Physician:	Primary Care Physician:
Physician's Phone:	Physician's Phone:
Insurance Company:	Insurance Company:
Insurance Policy #:	Insurance Policy #:

Child's Name:	Child's Name:
DOB:	DOB:
Primary Care Physician:	Primary Care Physician:
Physician's Phone:	Physician's Phone:
Insurance Company:	Insurance Company:
Insurance Policy #:	Insurance Policy #:

Child's Name:	Child's Name:
DOB:	DOB:
Primary Care Physician:	Primary Care Physician:
Physician's Phone:	Physician's Phone:
Insurance Company:	Insurance Company:
Insurance Policy #:	Insurance Policy #:

Please list any additional children on a separate sheet.

Please list any pertinent allergies your child[ren] has [have]:

CHILD: ALLERGY

____

____

____

____

Child's Name:	Child's Name:
DOB:	DOB:
Primary Care Physician:	Primary Care Physician:
Physician's Phone:	Physician's Phone:
Insurance Company:	Insurance Company:
Insurance Policy #:	Insurance Policy #:

Child's Name:	Child's Name:
DOB:	DOB:
Primary Care Physician:	Primary Care Physician:
Physician's Phone:	Physician's Phone:
Insurance Company:	Insurance Company:
Insurance Policy #:	Insurance Policy #: