



## Medical & Publicity Release Form

**Please bring a signed medical & publicity release form to the warm up area for each participant on your performance day.**

Each participant will be matched to a medical & liability form and hand stamped.  
Anyone without a form will NOT be permitted to practice or perform.

**SIX FLAGS GREAT ADVENTURE: *Please copy this form for EACH participant.***  
**MEDICAL AND PUBLICITY RELEASE FORM**  
*(Please print clearly)*

Participants Name: \_\_\_\_\_

School/Group Name: \_\_\_\_\_

**1. Medical Release**

- a. I understand that by taking part in this or any contest there is a possibility of injury or sickness to me/my minor child; therefore, I give permission for me/my minor child to participate in the Cheerleading and Dance Championship at Six Flags Great Adventure in Jackson NJ, and do hereby grant permission to Six Flags Great Adventure medical staff and hospital staff members to administer immediate treatment to me/my minor child should I/she/he be injured.
- b. I also agree to hold harmless Six Flags Great Adventure, Six Flags Inc., its officers and agents for any injury or loss of life, incurred as a result of me/my minor child's participation in the Cheerleading and Dance Championship.

**2. Publicity Release**

- a. I except where prohibited by law, I hereby irrevocably grant to Six Flags Great Adventure and its parent companies, successors and assigns, the absolute right and permission to use my name, photograph, video, hometown and state for promotional purposes in any manner or media whether now existing or hereafter created (including, without limitation, in publications and online), worldwide, in perpetuity, without notice to me and without limitation, condition, consideration, consent or compensation. I shall have no right of approval, no claim to any compensation, and no claim rising out of the use, alteration, distortion or illusionary effect or use in any composite form of any of the foregoing attributes of my identity.

Participants/Parents Name:

Print: \_\_\_\_\_ Sign: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Any Medication Allergies: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Doctors Phone: \_\_\_\_\_