

Association House of Chicago



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Chicago, Illinois 60651
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Fax: (773) 384-0560

Medical Release of Liability Form

Date of Incident : _____

Location of Incident : _____

Staff present/first at scene with participant : _____

Brief Summary of incident. Staff needs to complete a full report using the Agency Incident Report form within 24hours of documented incident.

Release of Liability Participant Statement

I, _____ (print name) have been given the option to seek medical attention following the briefly described incident above. I am voluntarily electing not to seek medical treatment and release the Association House of Chicago and their agent (staff) of any and all liability associated with this incident.

Signature of individual involved in incident

Date

Signature of Guardian/State Ward (if applicable)

Date

Signature of staff completing this form

Date

Signature of witness (if applicable)

Date