Medical Authorization and Indemnity Waiver

Name of Participant:

Date of Birth:

Address:

Phone Number:

Emergency Contact Name:

Emergency Contact Number:

Medical Information

Allergies/Medical Conditions:

Current Medications:

Health Insurance Provider:

Policy Number:

Primary Physician:

Physician's Phone:

Medical Authorization

I hereby authorize any licensed physician, medical technician, hospital or clinic to provide such medical treatment as may be necessary or advisable for the health and well-being of the participant named above, including in a situation in which I cannot be reached to give consent.

Indemnity and Waiver

I acknowledge and agree that participation in activities may involve inherent risks. I hereby waive, release, and discharge any and all claims for damages, injuries, or loss that may arise from such participation and agree to indemnify and hold harmless the organizers, their agents, and affiliates from any such claims.

☐ I have read and agree to the terms above.

Signature of Participant/Parent or Guardian

Date