

PARTICIPANT NAME _____

District 11 4-H Program
RELEASE FORMS

CAMP AND ENRICHMENT PROGRAM

WAIVER, INDEMNIFICATION, AND MEDICAL TREATMENT AUTHORIZATION FORM

1. EXCULPATORY CLAUSE. In consideration for receiving permission for my/my child's participation in any and all activities of **District 11 4-H Program** (herein referred to as "camp"), which is sponsored by **Texas AgriLife Extension Service, a member of The Texas A&M University System and its Texas 4-H and Youth Development Program**, (herein referred to as "sponsor"), I hereby release, waive, discharge, covenant not to sue, and agree to hold harmless for any and all purposes sponsor, The Texas A&M University System, the Board of Regents for the Texas A&M University System, Texas AgriLife Extension Service, Texas 4-H and Youth Development Program, Texas 4-H Youth Development Foundation, Texas A&M University, and their members, officers, servants, agents, volunteers, or employees (herein referred to as RELEASEES or INDEMNITEES) from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me/my child while participating in such activity, while traveling to and from the activity, or while on the premises owned or leased by RELEASEES, **including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of RELEASEES**, I understand this waiver does not apply to injuries caused by intentional or grossly negligent conduct.

2. INDEMNITY CLAUSE, I am fully aware that there are inherent risks to my child, myself and others involved with participation in any and all activities at the District 11 4-H Program, and I choose to voluntarily participate/allow my child to participate in said activity with full knowledge that the activity may be hazardous to me, my child and my property, and to the person and property of others. I acknowledge there may be physically strenuous activities. I know of no medical reason why I/my child should not participate. **I agree to indemnify and hold harmless INDEMNITEES** from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, which may occur to myself, my child, other participants, and third-persons as a result of my/my child's participation in said activity, **including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of INDEMNITEES**.

3. NO INSURANCE. I understand that RELEASEES may or may not maintain any insurance policy covering any circumstance arising from my/my child's participation in this activity or any event related to that participation. As such, I am aware that I should review my personal insurance coverage. Sponsor may not carry general liability insurance to cover claims arising from this activity so it seeks a waiver of claims as additional consideration for the right to participate so sponsor can (a) provide the activity at the lowest possible cost to participants; and (b) provide access to a greater number of participants by expending limited resources on program materials rather than on liability insurance.

4. BINDS HEIRS. It is my express intent that this agreement shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representatives, if I am deceased, and shall be governed by the laws of the State of Texas.

5. MEDICAL AUTHORIZATION, INDEMNITY FOR MEDICAL EXPENSES, and WAIVER. I understand RELEASEES cannot be expected to control all of the risks articulated in this form and RELEASEES may need to respond to accidents and potential emergency situations. Therefore, I hereby give my consent for any medical treatment that may be required, as determined by a medical professional at the medical facility, during my/my child's participation in this activity with the understanding that the cost of any such treatment will be my responsibility. I agree to indemnify and hold harmless INDEMNITIES for any costs incurred to treat me/my

child, even if an INDEMNITEE has signed hospital documentation promising to pay for the treatment due to my inability to sign the documentation. I further agree to release, waive, discharge, covenant not to sue, and agree to hold harmless for any and all purposes, RELEASEES from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me/my child while receiving medical care or in deciding to seek medical care, including while traveling to and from a medical care facility, including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of RELEASEES. I understand this waiver does not apply to injuries caused by intentional or grossly negligent conduct.

6. VOLUNTARY SIGNATURE. In signing this agreement I acknowledge and represent that I have read it, understand it, and sign it voluntarily as my own free act and deed; sponsor has not made and I have not relied on any oral representations, statements, or inducements apart from the terms contained in this agreement. I execute this document for full, adequate and complete consideration fully intending to be bound by the same, now and in the future. I understand I can choose not to sign this document and free myself and my child from its terms and the associated risks of the activity by simply not participating in the activity and choosing some other activity available to me/my child that has a lower level of risk to myself/my child. I further understand this is a voluntary, extracurricular activity. While I understand alternative activities are available to me/my child that do not have the risks associated with this activity I still desire to voluntarily engage/permit my child to engage in this activity.

**SIGNING THIS DOCUMENT INVOLVES THE WAIVER OF VALUABLE LEGAL RIGHTS.
CONSULT YOUR ATTORNEY BEFORE SIGNING THIS DOCUMENT.**

SIGNED this _____ day of _____, 20____

Participant Signature: _____

Printed Name: _____

Participant's Date of Birth: _____

Parent or Legal Guardian Signature:
(If participant is under 18 years old) _____

Parent or Legal Guardian Printed Name:
(If participant is under 18 years old) _____

In case of emergency, contact _____

at the following number _____

If the participant has medical insurance, please indicate:

Insurance Company: _____

Policy Number: _____

Name of Primary Policy Holder: _____

Please list any special services your child may require: _____

District 11 4-H Program
HEALTH STATEMENT

Check one: ____ Youth ____ Adult
Event: __D11 Junior Leader Lab_____

County _____
Event date(s): __July 9, 2013_____

The proposed activity provided by the District 11 4-H Program, requires participation in physical exercises, which are, by their nature, physically demanding. Many of the activities will challenge you, and cause surges in blood pressure and pulse rates. It is imperative that you are free of any heart related or other disease. Therefore, all participants must be free of medical or physical conditions which might create undue risks to themselves or any others who depend on them. If there is any doubt about your ability to safely participate in this experience, you should have a physical examination.

Section I. Participant Information

Name _____	Date of Birth _____ Age ____ Gender ____
Address _____	Name of Physician _____
City, State, Zip _____	Physician's Phone _____
Home Ph _____	Date of last physical exam _____

Section II. In the event of an Emergency, please contact:

Name _____	Home Ph _____
Address _____	Work Ph _____
City, State, Zip _____	Cell Ph _____

Section III. Health History (Check the appropriate answer and explain any YES responses.)

Have you had or do you currently have any heart problems (dates): _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you frequently suffer from pains in your chest: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
(NOTE: If you have any heart related problems you will need to have a physician's release.)	
Do you often feel faint or have spells of severe dizziness: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Has a doctor ever told you that you might have high blood pressure: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Are you a smoker: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you have arthritis, joint, or back problems that can be aggravated by exercise: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you had any operations or serious injuries (dates): _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you have any chronic recurring illness or communicable diseases: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Are there any activities to be limited/discouraged by a physician's advice: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Are you allergic to any medications, food or food ingredients, insects, or pollens: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you have Epilepsy: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you have Diabetes: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you have any prescribed meal plan or dietary restrictions (please describe) _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Any other health related information for Center personnel to be aware of: _____	

Section IV: Medications (ALL medications must be in ORIGINAL container with ORIGINAL LABEL.)

Are there prescribed medications currently being taken (please describe) _____ YES ☐ NO ☐

Please check "over the counter" medications which camp personnel may administer as necessary:

____ Immodium	____ Pepto Bismol	____ Ibuprofen (Motrin)	____ Acetaminophen (Tylenol)
____ Neosporin	____ Benadryl	____ Calamine/Caladryl	____ Any as needed

Section V. Insurance Information

Carrier: _____	Do you carry family medical/hospital insurance? YES <input type="checkbox"/> NO <input type="checkbox"/>
	Policy Number: _____

Signature of Participant: _____ Date: _____
(Or guardian if participant is under the age of 18)