



LEXINGTON Emmaus COMMUNITY

Emergency Medical Release & Liability Waiver

Flight # _____, from _____ through _____

Participant's Name _____ Birth date _____

Street Address _____ City _____ Zip _____

EMERGENCY INFORMATION

Father's Name _____ Home Phone (____) _____ Other Phone (____) _____

Mother's Name _____ Home Phone (____) _____ Other Phone (____) _____

In an emergency when parent/guardian cannot be reached, please contact the following:

Name _____ Home Phone (____) _____ Other Phone (____) _____

Name _____ Home Phone (____) _____ Other Phone (____) _____

Allergies _____

Other Medical Conditions _____

Physician _____ Home Phone (____) _____ Bus Phone (____) _____

Medical/Hospital Insurance Company _____ Phone (____)

Policy Holder's Name _____ Policy Number _____

THIS AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT MUST BE COMPLETED BEFORE A YOUTH BEGINS THE CHRYSALIS FLIGHT. TREATMENT FOR INJURY WILL BE BASED ON INFORMATION PROVIDED HEREIN.

I the undersigned (if applicant/participant is 18 years of age or older) or parent/guardian of the above listed minor applicant/participant acknowledge and fully understand that each applicant/participant will be engaging in activities that could involve risk of injury, including permanent disability or death, and severe social and economic losses which might result not only from their own actions, inactions or negligence, but action, inaction or negligence of others, or the condition of the premises or of any equipment used and further, that there may be other unknown risks not reasonably foreseeable at this time, assume all the foregoing risk and accept personal responsibility for the damages following such injury, permanent disability or death, hereby release, discharge, covenants to indemnify and not to sue the Lexington Emmaus Community, its affiliated organizations and sponsors, the volunteer leaders, officers, directors, agents, including the owners and lesers of premises used to conduct the event, all of which are hereinafter referred to as 'releasees', from any and all liability to each of the undersigned, his/her heirs or next of kin for any and all against any claim by or on behalf of the applicant as a result of the applicant's participation in the Programs and/or being transported to or from the same, which participation, after careful consideration I hereby authorize, and which transportation I hereby authorize.

I hereby give my consent to have a doctor of medicine or dentistry or associated personnel including nurses to provide the applicant/participant with medical assistance and/or treatment and agree to be financially responsible for the cost of such assistance and/or treatment. I also agree to save and hold harmless and indemnify each and all parties herein referred to above as releasee from all liability, loss, cost, claim or damage whatsoever, including death or damage to property, which may be imposed upon said releasee because of any defect in or lack of such capacity to so act or caused or alleged to be caused in whole or in part by the negligence of the releasee. I have read the above waiver/release and understand that (I)we have given up substantial rights by signing this release and sign below voluntarily.

Signature _____ Date _____

NOTE: ATTACH COPY OF YOUR INSURANCE CARD, FRONT AND BACK, TO EXPEDITE MEDICAL TREATMENT.