

Liability and Assumption of Risk

Please complete BOTH sides

Participant Information

Name _____ Age _____

Street Address _____

City, State, Zip _____

Telephone (home) _____ (Work) _____

E-mail address _____

Photo/Media Release

I grant Napa County Office of Education Ropes Course and persons acting for or through them the right to use, reproduce, assign, and/or distribute photographs, films, video tapes, and sound recordings of me for use in materials they may create.

Disclosure

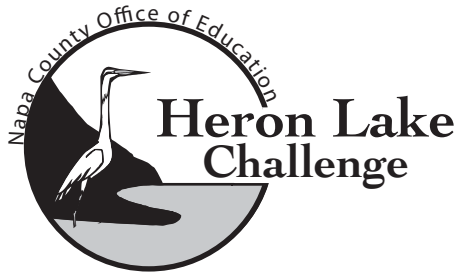
Napa County Office of Education Ropes Course Program involves a variety of activities that often include warm-ups, games, group initiative problems, high and low ropes course elements, and other rigorous physical adventure activities. The level of participation in a Napa County Office of Education Ropes Course activity is at all times completely up to the individual's choice. Yet there is a risk, which must be assumed by each participant, that he or she may suffer a serious injury/illness and/or disability.

RELEASE OF LIABILITY AND ASSUMPTION OF RISK

I am fully aware that the Napa County Office of Education Ropes Course Program that I am choosing to participate in may be physically or emotionally demanding. I affirm that my health is good and that I am not under a physician's care for any undisclosed condition that bears upon my fitness to participate in Napa County Office of Education Ropes Course activities. I voluntarily elect to participate in the program and to assume the risk of injury or harm that could result from participation. I release Napa County Office of Education, Napa County Office of Education Ropes Course Program and its staff members, and the Napa County Board of Education from all liability for any injury, harm, or damage from participating in the Napa County Office of Education Ropes Course program, whether the injury or harm is caused by the negligence of Napa County Office of Education Ropes Course or otherwise. This release is binding upon my heirs, executors, and assigns. I have read and understand this release of liability. I voluntarily sign it.

PARTICIPANT SIGNATURE

PARENT/GUARDIAN SIGNATURE
(Must be over 18 years of age to sign for minor)



Medical Information and Release

Please complete BOTH sides

Policy for participation in all Napa County Office of Education Ropes Course programs requires that every participant has health/accident insurance coverage or waives the requirement of having insurance coverage. In addition, certain health/medical information must be made known to the instructor(s) conducting programs so that they are prepared to respond appropriately if the need arises. This information will be held in confidence.

1. Does participant have health/accident insurance? YES NO

Insurance company _____ Policy No. _____

Primary physician _____ Phone _____

2. Do you have any allergies, reactions to medications, or any other medical limitations? YES NO

If yes, identify and explain: _____

3. Are you currently taking medication (prescribed or otherwise, i.e., cold medicine)? YES NO

If yes, state what you are taking and the condition for which you are taking it: _____

4. Do you have any limiting physical disabilities or handicaps (temporary or permanent)? YES NO

If yes, identify and explain: _____

Authorization to Treat a Minor: (Must be completed for all persons under 18 years of age.)

I (We) the undersigned parent(s) or legal guardian of _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, or medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff or emergency room staff licensed under the provision of the Medical Practice Act or dentist licensed under the provision of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is give to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment of the patient.

PARENT/GUARDIAN SIGNATURE

DATE