



Fort HealthCare
Camp 911

PARTICIPANT AGREEMENT/ACKNOWLEDGEMENT AND RELEASE FORM

Please read this Agreement CAREFULLY before signing.

You, the undersigned Participant, have applied to participate in "Camp 9-1-1" which is conducted by Fort HealthCare in partnership with local EMS providers and educators, area law enforcement entities, and public safety officials (the "Contributors"). You realize that the Camp 911 Program (the "Program") may include: exercises, use of safety equipment, walking, running and lifting. Its purpose is to provide participants training in injury prevention, bystander emergency care, and health and wellness. The program is not recreational. Participant is aware in signing this Form that certain elements of the Program require participation and that not all hazards and dangers associated with the activities can be foreseen. Participant understands that certain risks, dangers and injuries, including fatality, due to acts of God, inclement weather, slipping, falling, insect bites, equipment failure and other circumstances may exist in the Program's activities. Participant recognizes that it is impossible for Fort HealthCare or the Contributors to guarantee absolute safety.

Participant understands and voluntarily assumes all risks, dangers and injuries associated with participation in this Program and agrees that neither Fort HealthCare, the Contributors, nor their officers, directors, employees, agents or other representatives in any capacity shall be responsible for any loss, damages, or injuries resulting to Participant, in the absence of gross negligence imputable to the sponsors. Participant further agrees to release, indemnify and hold the Contributors and their directors, officers, employees, agents and other representatives in any capacity, harmless from or for any claims, causes or action, liabilities or damages that may arise as a result of or in connection with Participant's participation in the Program.

Participant expressly agrees to observe all the Program's safety regulations and directions as interpreted and enforced by the Program's activity leaders. Participant voluntarily assumes and accepts responsibility for all risks, dangers and injuries resulting from his/her failure to obey safety regulations and directions of activity leaders or from the exercise of judgment by such activity leaders made in good faith based on then existing circumstances.

Participant has read and understands this Participant Agreement/Acknowledgment and Release Form. Participant's signature(s) on this document is also intended to bind his/her/their heirs, representatives, administrators and assigns.

Participant assumes full responsibility for his/her health and certifies that he/she is free of/or will notify his/her instructors of, any medical, physical or emotional conditions which might create undue risk for Participant or others. Participant agrees to exercise good judgment in regard to his/her health safety, and well-being while participating in this Program. If for any reason Participant questions his/her ability to participate in the activity, Participant will tell his/her instructor prior to participation.

I FULLY UNDERSTAND THE NATURE OF THE PROGRAM ACTIVITIES. I GIVE MY CONSENT FOR EMERGENCY MEDICAL TREATMENT AND HEREBY AUTHORIZE AT MY EXPENSE THE CALLING OF MEDICAL PERSONNEL TO PROVIDE WHATEVER EMERGENCY MEDICAL OR SURGICAL TREATMENT IS NECESSARY.

I have signed this Form on behalf of the Participant listed below, and I certify that I am the parent or legal guardian of Participant.

PARTICIPANT: _____
(print name)

PARENT/LEGAL GUARDIAN: _____
(print name)

SIGNED: _____ DATE: _____

Emergency Contact Information

Name: _____ Relationship to Participant: _____

Phone: _____

Name: _____ Relationship to Participant: _____

Phone: _____

Participant's Medical Information

Medical History that may affect participation in Camp 911 _____

Medications to be given at camp (including dose and times): _____

Rescue/Emergency Medications (including dose and indication): _____

Allergies _____

Dietary Restrictions _____

Primary Care Physician _____ Phone Number _____



