AWSC KAOS

Assumption of Risk Agreement and Release

The undersigned assumes all responsibility for and all risk of damage, injury, death, loss of personal property and expenses, personal negligence in participating, that may occur to the undersigned while attending any AWSC KAOS activity and participating in exercises or following activity instructions. In consideration of being accepted as a participant the undersigned hereby releases and discharges the AWSC and the KOAS Youth Program, its officers, organizers and chaperones from all claims, demands, rights or causes of action present or future, whether known, anticipated or unanticipated, and resulting from, arising out of, or incident to, the undersigned=s participation in the activity. I have read, understood, and accepted the terms and conditions listed herein and acknowledge that this agreement shall be binding and sign the Assumption of Risk Statement and Release.

Dated this _____________ day of _______________________________, 20_____.

Participant's Name____

Participant's Signature ____

Parent/Guardian's Signature ____

Snowmobile Liability Insurance:
Insurance Company: ____

Phone Number: (   ) ____

Policy Number: ____

Revised: August 18, 2015

PARENT/LEGAL GUARDIAN
EXCURSION WAIVER

We, as parents or guardians of ____
(Name of Participant)
grant our permission and consent to participate in any activities planned by the AWSC, the KAOS YOUTH LEADERSHIP organization and any KAOS committee members.

In granting and accepting such permission and consent, we specifically recognize that such consent and participation in the activity is voluntary.

In granting such permission and consent, we:

Expressly recognize that these trip may entail traveling and therefore, we accept and assume all responsibility and risks related to such travel.

Acknowledge and assume full responsibility for any and all damage to person or property caused by our child or ward during such activity.

Expressly authorize emergency medical or dental treatment deemed necessary by the participating adults during such activity.

Expressly agree that in the event that any disciplinary action or the health of my child requires that my child be returned home during such activity that such return shall be accomplished at our expense.

Expressly agree that we, the undersigned, waive and release all claims against the club officers, activity organizers or accompanying chaperones on this activity, from any injury, loss, damage, accident, medical care, delay or expense regardless of its cause. We also release the officers, organizers or chaperones from any financial obligation incurred by us and agree to indemnify them with regard to any such liabilities that we or our child/ward may cause while participating in this trip.

We expressly acknowledge that we have carefully read this statement and understand its impact and effect. We acknowledge and understand that if we have any questions in regard to this statement that we have exercised our right to have it reviewed and further explained to us prior to our signing.

Dated this ______ day of ______________, 20___.

____ (Signature of Parent or Guardian)

____ (Signature of Parent or Guardian)

_____________________   ____
(Phone)   (Address-parent/guardian) (City) (State) (Zip)

Revised: August 18, 2015

Medical Information and Treatment Permission Form

Name ________________________________ Birth Date ___________________________________

Please Check the following information regarding your child.

Yes No

_____ _____ Asthma - What triggers attacks? ____
Specify treatment and frequency ____

_____ _____ Diabetes - Specify diet and testing routine ____________________________________

_____ _____ Seizures - Specify frequency and type of seizures ______________________________

_____ _____ Heart Disease/High Blood Pressure - Specify ________________________________

_____ _____ Allergies - Specify agent and treatment ______________________________________
Does your child have an Epi Pen for emergency use? Yes_______ No _______

_____ _____ Physical Handicap - Specify ____

_____ _____ Vision or hearing impairment - Specify _____________________________________

_____ _____ History of serious injury, surgery, accidents, or other medical conditions that would be of significance ____
____

_____ _____ Is youth taking medication: Specify drug, frequency and reason taken:

____

____

____

Each participant will be responsible for administering their own medications while on the trip. Only enough medication should be sent for the duration of the trip. All medications should be in the original containers. Youth should bring any over the counter medication that they might require.

Date of last Tetanus Immunization __________________________________

Physician ______________________________ Office Phone #: (_____)________________________
Dentist ________________________________ Office Phone #: (_____)________________________

I give my permission for the above health information to be shared with any medical personnel if necessary. I understand that the information will be handled in a confidential manner.

Parent Signature ________________________Date_________

Authorization to Consent to Medical Treatment

On rare occasions, an emergency requiring treatment, hospitalization, and/or surgery develops. While every effort will be made to contact parents or guardian before any treatment is given, the below authorization could prevent dangerous delay in the event parents cannot be contacted.

I/We, the undersigned, parent(s) of ___________________________________ do hereby authorize the chaperones of the KAOS YOUTH activity to give consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of the physician or surgeon in charge.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

I understand that I am responsible for medical expenses or evacuation expenses incurred that are not covered by my health insurance policy. This authorization shall remain in effect throughout the duration of the youth's participation in this year's program.

Parent/legal guardian signature(s) _______________________________________ Date _________

____ Date _________

Preferred Hospital System: ____

Primary Insurance Company _______________________________Policy Number________________
Phone Number (_____)_________________________
Secondary Insurance Company _____________________________Policy Number________________
Phone Number (_____)_________________________

Mother=s Name ______________________________ Home Phone (_____)________________
Work Place ________________________________ Work Phone (_____)________________

Father=s Name ______________________________ Home Phone (_____)________________
Work Place _________________________________Work Phone (_____)_________________

Emergency Contact (other than parent)
Name _____________________________________ Relationship to youth ______________________
Home Phone (_____)_________________________Work Phone (_____)________________________

****
Comments:

Revised: August 18, 2015