#### Agreement for Assumption of Risk, Indemnification, Release, and Consent for Emergency Treatment

I, \_\_\_\_\_\_ (print name), age \_\_\_\_\_\_, desire to voluntarily participate in LWD CAMP and associated activities and any recreational activities at the Palos Verdes High School.

I UNDERSTAND THAT I AM BEING ASKED TO READ EACH OF THE FOLLOWING PARAGRAPHS CAREFULLY. I UNDERSTAND THAT IF I WISH TO DISCUSS ANY OF THE TERMS CONTAINED IN THIS AGREEMENT, I MAY CONTACT JORDAN GREY AT LWD@HEAVENTOTHEYEAH.ORG.

#### **Assumption of Risks:**

I understand that participation in this voluntary activity, by its very nature, carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The specific risks vary from one activity to another, but in each activity the risks range from: 1) minor injuries such as scratches, bruises, and sprains to 2) major injuries such as fractures, internal injuries, joint or back injuries, heart attacks, and concussions to 3) catastrophic injuries including paralysis and death. I understand that LWD CAMP has advised me to seek the advice of my physician before participating in this activity. I understand that I have been advised to have health and accident insurance in effect and that no such coverage is provided for me by LWD CAMP. I know, understand, and appreciate the risks that are inherent in the above-listed programs and activities. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.

Signature:	Date:	_ Date:		
Signature of Parent or Guardian				
(if Participant is Under 18) :		Date:		

#### Hold Harmless, Indemnity and Release:

In consideration of permission for me to voluntarily participate in \_\_\_\_\_\_\_, today and on all future dates, I, for myself, my heirs, personal representatives or assigns, agree to defend, hold harmless, indemnify and release the LWD CAMP, Let Women Decathlon, Heaven to the Yeah, and their officers, employees, agents, and volunteers, from and against any and all claims, demands, actions, or causes of action of any sort on account of damage to personal property, or personal injury, or death which may result from my/my child's participation in the above-listed program. This release includes claims based on the negligence of LWD CAMP, Let Women Decathlon, Heaven to the Yeah, and their officers, employees, agents, and volunteers, but expressly does not include claims based on their intentional misconduct or gross negligence. I understand that by agreeing to this clause I am releasing claims and giving up substantial rights, including my right to sue.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Guardian
(if Participant is Under 18): \_\_\_\_\_ Date: \_\_\_\_\_

#### **Consent for Emergency Treatment:**

I authorize LWD CAMP and its designated representatives to consent, on my/my child's behalf, to any emergency medical/hospital care or treatment to be rendered upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

Signature:	Date:
Signature of Parent or Guardian (if Participant is Under 18):	Date:
Medication:	
ward is to be self administered or administered by the can ward to be responsible for their own medicationYe If NO, all medications brought to camp by a camper shall	ribution and medical devices, whether brought by your son, daughter, or np health supervisor. Therefore, do you wish your son, daughter, or esNo be: (a) in containers which identify the medications and the name of the the camp health staff as prescribed by a licensed physician with a
Signature: Signature of Parent or Guardian	Date:
(if Participant is Under 18)	Date:

\*If your son, daughter or ward will be under 18 while participating in or through activities at LWD CAMP, it is our policy to request your agreement to the above terms, on behalf of your minor son, daughter or ward.



let Worrer Becathlor 💙	<b>↓ Heaven</b> ≩ <b>Yeah</b> ® y	OUTH EVENT HEALTH FORM		
Youth Name (inc	clude middle and la	ast names):	// Birth Date:	
	ale. 🗌 Female refer not to say	Ethnicity: 🗌 Hispanic 🗌 Non-Hispanic	Race: African American	Asian Other
<b>Custodial Parent</b>	/Guardian (or spol	Email Address:		
Phone Numbers:	Home: (	) Work: ( )	Cell: ( )	
Home Address:	Street	City	State	Zip
Second parent/gu and/or emergenc			Phone: ( )	
Address:				
	Street	City	State	Zip

## **CONSENT FOR MEDICATION ADMINISTRATION AND MEDICAL TREATMENT**

### TO THE PARENT(S) OR LEGAL GUARDIAN:

If your son, daughter, or ward will be under the age of 18 while at LWD CAMP, it is event/camp policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device must be administered by designated event/camp health staff with the exception that a limited amount of medication for life-threatening conditions may be carried by my son/daughter/ward (i.e. bee sting kit, inhaler, insulin syringe).

Prescription medication(s) has been brought to event/camp. All prescription medication must be in the original medicine bottle and labeled
with the youth participant's name, doctor's name, medication name, dosage, prescription number, date prescribed, and instructions. Also,
information about any prescription medications must be provided in writing to event/camp health staff with the information requested on the
second page of this form.

Over-the-counter medications have been brought to event/camp and may be administered by camp health staff as needed. All over-the counter medications must be labeled with the youth participant's name, medication name, dosage, and instruction.

☐ No medication(s) has been brought to event/camp.

# If your son, daughter, or ward will be under the age of 18 years while at the event/camp, it is our policy to secure your agreement to all of the following statements. By signing below:

• I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.

• I am stating that I am aware of and accept the risk inherent in the program activity.

• I attest that all information on both sides of this form is correct and up-to-date, and that I will provide any and all significant, material, or important changes to any information in this form to event/camp staff no later than check-in.

• I agree to hold harmless and indemnify LWD CAMP, Let Women Decathlon, Heaven to the Yeah, their officers, agents, and employees from any and all liability, loss, damages, costs, or expenses which are sustained, incurred or required arising out of the actions of my son, daughter or ward in the course of the event/camp.

PARTICIPANT NAME (PLEASE PRINT)



Participant Name: \_\_\_\_\_ Parent/Guardian Signature:

lealth Conditions (check all that apply):	Allergies (check & list specifics):		
<ul> <li>Asthma</li> <li>Diabetes</li> <li>Epilepsy</li> <li>Psychiatric</li> <li>Cognitive/Developmental</li> <li>Any dizziness, light-headedness or fainting associated with exercise within the past year</li> </ul>	<ul> <li>Insect stings</li> <li>Foods</li> <li>Medications</li> <li>Other</li> </ul>		
Any unexplained, rapid or irregular heart beat within the past year	Do any allergies require an EPIPEN Injection? Yes No Is an inhaler required and carried by youth? Yes No Date of last Tetanus booster :		
A physician has sometime denied or restricted participation in sports due to a heart problem			
Name of Insurance Co.:	Policy #:		
Please describe any limitation or restriction of event a	ctivities:		

Any special accommodations regarding physical or emotional conditions that we need to be aware of regarding your child's participation in this event/camp (include circumstances when physician should be notified)?

Medications camper will be taking at camp:

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Name of Medication	Reason	Dosage (mg)	Times of day given	Prescribing Physician Name & Phone Number

1. Does the youth experience any side effects from the medication? (i.e., mood/behavior changes, upset stomach, 🗌 Yes 🗌 No diarrhea)

2. List any special instructions or additional information regarding the medication that would be helpful to the Health Care staff:

Information provided by:	To:	Date:	
If NO, list the name & phone number of per side of this form:	son(s) authorized to make decisions on their b	ehalf if different than the emergency contact listed on the reverse	
Will the custodial parent(s) or guardian be available at the numbers listed on this form during the camping session? 🗆 No 🗆 Yes			
Does your child have any recent injury or activity restrictions? 🗌 No 📋 Yes			
Are there any changes in your dependent's medications? (If Yes, Staff make changes & sign) 🗌 No 🔲 Yes			
Does your child now have any rashes or open sores? 🔲 No 🛄 Yes			
Has your child, or anyone in your family been sick or exposed to any communicable disease in the past month? 🗆 No 🗔 Yes			
Are there any changes in your child's healt	there any changes in your child's health status since the medical forms were sent in? $\Box$ No $\Box$ Yes		
*** FOR EVENT/CAMP USE O	** FOR EVENT/CAMP USE ONLY – TO BE COMPLETED BY HEALTH CARE STAFF AT CHECK-IN ***		