

## LIFE Program Liability Waiver and Authorization to Treat

**Liability Waiver:** I know that participating in the activities of the LIFE Program is potentially hazardous. I should not participate unless I am medically able and properly trained. I also assume any and all other risks associated with participating in any LIFE Sponsored activity including but not limited to falls, the effects of the weather including altitude, cold, and heat, and the condition of the environment, all such risks being known and appreciated by me. Knowing these facts, I hereby for myself, my heirs, executors, administrators or anyone else who might claim on my behalf covenant not to sue, and waive, release, and discharge the LIFE (Lifelong Instruction and Focus on Exploration) Program, including their staff and any and all supporters or anyone acting for or on their behalf from any and all claim for liability for death, personal injury or property damage of any kind or nature whatsoever arising out of or in the course of my participation in this program. I also hereby consent to permit emergency treatment in the event of injury or illness. This release and waiver extends to all claims of every kind or nature whatsoever, foreseen or unforeseen, known or unknown.

**Medical Authorization:** The person herein described has my express consent to participate in all LIFE Program Sponsored activities, except as noted. By giving this consent, I expressly acknowledge that I have been made aware that I/my child may be exposed to the risks of nature and of the elements over which the LIFE Program has no control. Having been informed of such risks, I specifically agree that I/my child may participate in the program. I hereby give permission to the physician selected by the LIFE Program director to order X-rays, routine tests, treatment, and emergency transportation for the health of me/my child. I hereby give permission to release the results of any of the aforementioned tests or treatment to the LIFE Program. In the event I cannot be reached in an emergency, I hereby give permission to the physician or medical facility selected by the LIFE Program director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/my child as named above. I accept responsibility for medical/surgical treatment charges which may be incurred on my/my child's behalf. I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for his services as described but not to exceed the reasonable and customary charges for those services. I understand that if I have no health insurance, the LIFE Program will not provide any coverage and that I will be responsible for paying any charges. I understand that if I have health insurance, I accept responsibility for the cost of any treatment, prescriptions and/or related expenses for my/my child's care.

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**Print Participant's Name**

**Participant's Signature**

**Date**

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**Print Parent/Guardian's Name**

**Parent/Guardian's Signature**

**Date**

## LIFE Program Participant Medical Form

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Email \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

Work Address \_\_\_\_\_ Phone \_\_\_\_\_

Second Parent/Guardian \_\_\_\_\_ Email \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

Work Address \_\_\_\_\_ Phone \_\_\_\_\_

If not available in an emergency, notify \_\_\_\_\_ Phone \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist/Orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Name of Primary Insured \_\_\_\_\_ Phone \_\_\_\_\_

Special Health Concerns/Allergies:

Current Medications/Dosages per day:

Health History – Any previous conditions/surgeries/treatments?