HIGH ROPES, INITIATIVES, & LIGHTHOUSE CLIMB WAIVER

Participant's Name	Birth Date	Group Name

STATEMENT OF UNDERSTANDING

I am aware in signing this statement for participation in the High Ropes, Initiatives, and Lighthouse Climb activities of Camp Westminster that certain activities are physically demanding. Therefore, physical fitness will increase the enjoyment and ability to participate in the activity. If, for any reason, I question my ability to participate in the activity, I will consult with the instructor prior to participation. While it is impossible to foresee all possible dangers, some of the specific hazards which I might encounter include: slipping or falling on trails, bumps, bruises, cuts, insect bites, poison ivy, sprains, fractures, or other injuries. The instructors of the course will take every reasonable precaution to minimize exposure to known risks, however, as a participant, I acknowledge the nature of the activities and the fact that not all the stresses and hazards connected with the activities can be foreseen. I have personal responsibility to follow established safety rules and procedures associated with each activity. If, at any time, I have questions about the activity, I have the responsibility to consult with the instructor. Please note that most activities are conducted out-of-doors in all kinds of weather, so dress accordingly.

I recognize that there is a significant element of risk in any adventure, sport, or activity associated with the out-of-doors. Knowing the inherent risks, dangers, and rigors involved in the activities, I certify that I, or my dependent, am fully capable of participating in the activities. I have adequate health insurance to cover costs of any health care that my dependent or I may incur during participation in the High Ropes, Initiatives, and Lighthouse Climb activities.

I accept full responsibility for bodily injury, death, loss of personal property and expenses thereof, as a result of my or my dependent's negligence, and release and waive any and all claims, demands and causes of action which I or my dependent may have against Camp Westminster and Westminster Church of Detroit, their members, representatives, agents or employees, for any bodily injury, including death, however caused, resulting from or arising out of or in any way connected with the High Ropes, Initiatives, and Lighthouse Climb. I additionally covenant not to cause any action at law or in equity to be brought or permit such to be brought on my behalf or on behalf of the individual named above, and agree to save indemnity and hold harmless and defend at my sole expense Camp Westminster and Westminster Church of Detroit from any claim, demand and cause of action which might be asserted against either of them or any employee or agent of theirs arising out of or by reason of said High Ropes, Initiatives, and Lighthouse Climb, and related activity. I further affirm that I understand that, even under the safest conditions possible, participation in any part of the High Ropes, Initiatives, and Lighthouse Climb may be hazardous, and assume the risk of any and all loss or injury resulting from or arising out of or in any way connected with the same for myself and my dependent, and specifically on behalf of the individual named above.

X_____

Signature of Participant Date

X_____

Signature of Parent or Legal Guardian (*if participant is under 18 years of age*) Date

NOTE: All participants should wear long pants and tennis shoes on the Low and High Ropes Initiatives Course and the Lighthouse Climb.

OVER

PARTICIPANT'S NAME_____Phone_____

Address_____
Street City State Zip

EMERGENCY MEDICAL INFORMATION

No ☐ Yes ☐ Allergies to foods, drugs, insect bites, dust. Please identify which and the nature of the reaction:

_____

No ☐ Yes ☐ Physical disabilities or conditions that might limit participation. Please identify:

_____

No ☐ Yes ☐ Medications taken regularly. Please list:

_____

Please list additional facts concerning participant's medical history to which a physician should be alerted:
(Attach additional page, if necessary.)

_____

_____

COMPLETE THIS SECTION TO GRANT CONSENT FOR MEDICAL TREATMENT FOR A PARTICIPANT UNDER 18 YEARS OF AGE.

Purpose: To enable parents and legal guardians to authorize the provision of emergency treatment for children who become ill or injured while under the care and authority of Camp Westminster, when parents or guardians cannot be reached. In the event that reasonable attempts to contact me at _____
(phone number)

or _____ at _____ have been unsuccessful, I hereby give my
(other parent or guardian) (phone number)

consent for: (1) The administration of any treatment deemed necessary by Dr. _____
(preferred physician)

at _____ or Dr. _____ at _____
(phone number) (preferred dentist) (phone number)

or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and

(2) the transfer of the child to_____ or any hospital reasonably
(preferred hospital)

accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed practitioners that concur with the necessity for such surgery is obtained prior to the performance of the surgery.

X_____
Signature (parent/legal guardian) Phone Date

_____
Address (City, State, Zip)