THE SWORD EXPERIENCE
REGISTRATION, PERMISSION, AND MEDICAL RELEASE FORM

I hereby consent that my son/daughter, _____, may participate in The Sword Experience ("TSE") on _____ _____, 20___ at _____, _____. I understand that I am responsible for arranging transportation for him/her to all designated pick-up and drop-off locations. As parent or legal guardian, I understand that I remain fully responsible for the actions of my son/daughter.

I give permission for my child/charge ("child") to participate in TSE. I understand that my child is expected to follow all applicable rules and policies of TSE and is expected to follow the directions provided by the instructor and/or other adult supervisors.

I have read, understand, and discussed with my child that:

(1) They are expected to follow explicitly the instructions of the adult supervisor and/or trainer;
(2) They are expected to respect each other, as well as the people that participate in TSE;
(3) Participation in TSE may potentially result in personal injuries or even death from accidents; and
(4) They are to remain in their assigned locations at the request of the supervisor or trainer.

I recognize that by participating in this activity, as with any activity involving swords or sharp objects, my child may risk personal injury or permanent loss. I hereby attest and verify that I have been advised of the potential risks, that I have full knowledge of the risks involved in this activity, and that I assume any expenses that may be incurred in the event of an accident, illness, or other incapacity, regardless of whether I have authorized such expenses.

As a condition for participation in TSE, I, for myself, my child, my executors and assigns, further agree to release and forever discharge TSE and its agents, officers, employees, and volunteers from any claim that I might have myself or that I could bring on my child's behalf with regard to any damages, demands or actions whatsoever, including those based on negligence, in any manger rising out of TSE activities or transportation during the retreat. I have read this entire waiver and permission form, fully understand it, and agree to be legally bound by its terms.

Furthermore, I give permission for any photos taken of my son/daughter during the TSE event to be used in any future publicity (i.e. print, broadcast, website) effort of TSE. I am aware that names will not be used.

I hereby agree on behalf of myself and my son/daughter to release TSE and any and all affiliated organizations, their employees, agents and representatives, including any and all volunteers, from any and all claims, including negligence, which may be asserted by me or my son/daughter, or behalf of my son/daughter, arising from or relating to my son/daughter's participation in TSE. In the event this release is held to be invalid or unenforceable, I hereby agree to indemnify and hold harmless TSE from any and all claims, including negligence, which may be asserted by me or my son/daughter, or behalf of my son/daughter, arising from or relating to my son/daughter's participation in TSE or while interacting with others involved in TSE. This release and indemnification does not apply to claims for intentional misconduct or gross negligence, nor does this release and indemnification apply to the extent of commercial insurance coverage for any claim, but this release and indemnification shall apply to the extent of any self-insurance or deductible applicable to any claim.

As a parent/legal guardian of the student named below, I do hereby authorize the leaders of this program to secure emergency medical or surgical treatment for my child, which in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. I further authorize the person who presents the minor to sign the Acknowledgement of Receipt of Notice of Privacy Rights that may be presented by the physician or health care facility. This medical authorization is completed of my own free will with the sole purpose of authorizing medical treatment deemed necessary/appropriate by the treating physician.

PLEASE COMPLETE THE FOLLOWING INFORMATION. PLEASE PRINT LEGIBLY.

Participant Info.

Name: _____Birth:____/____/____ Sex: ❑Male or ❑Female

Address: _____City:_____Zip:_____

Phone: (___) _____ E-mail: _____Grade:_____School:_____

Parent/Legal Guardian Info.

Name: _____Relationship: _____ Home Phone: (___) _____

Work Phone: (___) _____ Mobile Phone: (___) _____ E-mail: _____

Address: _____City:_____ Zip:_____

Medical Info.

Emergency Contact #1 (other than name listed above): _____ Phone: (___) _____

Emergency Contact #2 (other than name listed above): _____ Phone: (___) _____

Allergies: _____ Medications: _____

Other needs/concerns:_____

Physician: _____ Phone: (___) _____

Address: _____ City: _____ Zip:_____

Insurance Carrier: _____ Policy #: _____Group#: _____

PARENT/LEGAL GUARDIAN SIGNATURE: _____ Date: ____/____/____

Please return this completed form to:

_____

_____

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