Kiwanis Club of North Central Kiwanis Activity Consent Form and Release of Liability

Participant Name		Cell Pho	ne	Birthdate	Age	
Address		City, State, Zip				
Email of Participant		Email of Parent (if minor child)				
Has approval for travel and particip	g activity:		From	То		
INFORMED CONSENT, RELEASE AGRI understand that participation in act challenges in the activities offered. In Kiwanis. I also understand that participation applicable rules and the standards of the event I cannot be reached, permit anesthesia, surgery, or injections of rin charge and/or any physician or head information/Confidential Health Info §§160.103, 164.501, etc. seq., as a medical evaluation of the participant participant's ability to continue in the including preparations for and transprompletely release and waive any an activity coordinators, and all volunted continually monitor compliance of primposed on a youth participant in continual promotional and/or educational purposes.	ivities involves the ristormation about the information in these active conduct. In case of a sision is hereby given medication for my chalth care provider inversation (PHI/CHI) unended from time to to, follow-up and compart of the program activities. For the contation to and from the all claims for personers, related parties, contation with program activities and all claims for personers, related parties, connection with programs of the contact of the	sk of personal injuries activities may be vities is entirely volumented in emergency involuted in emergency involuted in providing ader the Standards ime, includes examination with the With appreciation in the activity, on mal injury, death, corrother organization any limitations in the sor activities be or video taken of near the standards.	ne obtained from the untary and requires living my child, I und ovider to secure profess are authorized to medical care to the for Privacy of Indivinination findings, te e participant's pare of the dangers and y own behalf and/or loss that may arisons associated with mposed upon them low and counsel you syself (or my minor	e venue, activity co participants to foll erstand that effort per treatment, incl o disclose protecte participant. Protec dually Identifiable st results, and treat nts or guardian, an risks associated with on behalf of my ce against Kiwanis Ir any program or act by parents or medi ur child to comply we child) to be used for	ordinators, or Nor low instructions are s will be made to uding hospitalizated d health information tred Health Health Information trent provided for d/or determination th programs and a hild, I hereby fully international, the local civity. NOTE: The kand	th Central and abide by all contact me. In ion, ion to the adult or 45 C.F.R. or purposes of on of the ctivities and ocal club, the ciwanis cannot any restrictions ions.
Participant restrictions			□ None □ As Lis	ted Below		
MEDICAL						
Insurance Carrier	Group/Policy #		D#	In	surance Phone	
Physician Name	Physician Phone	,	Allergies			
Medications (Name, Dosage, Directions)		<u>l</u>				
Participant Printed Name		Signature		Date	2	
Parent/Guardian Printed Name (Minor Participant)		Signature		Date	2	
Emergency Contact Name		Emergency Contact Phone				

Rev: 19-June-2023