Trail Volunteer Application (Minors)

Please fill out and email to: 9btrails@9btrails.org

Date:
Name:
Email Address:
Phone Number:
Emergency Contact:
Emergency Contact Relation:

RELEASE OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNIFICATION AGREEMENT

_____ has my (our) permission to participate and volunteer in 9B Trails (Boundary County Bike and Pedestrian Trails Committee, Inc.) volunteer projects.

By signing this agreement/liability waiver, I/we agree to indemnify and hold harmless 9B Trails its representing agencies, officers, directors, and staff/employees, other volunteers, and any other third party, including the owners and leasers of premises used to conduct the event acting officially or otherwise, from or resulting from my minor child's participation as a volunteer.

I/we understand and acknowledge that volunteer activities poses risks to my child, including the risk of bruises, scrapes, cuts, sprains. Furthermore, I acknowledge potential hazards associated with volunteering activities, may include but are not limited to; falls, falling rocks, fractures, concussion, weather, dehydration, hypothermia, wildlife, equipment failures, and negligence of others; as a consequence of these risks, my child may be seriously hurt, disabled or may die from the resulting injuries. Hospital facilities, qualified medical care, and emergency medical evacuation may be limited or unavailable.

I/we also attest that my child is physically fit and in good health to participate as a volunteer. In the event I/we cannot be reached in an emergency, I/we hereby give permission to the volunteer staff to secure proper treatment for my child. I/we do hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of the medical staff of the hospital or facility furnishing medical or dental services. It is further understood that the undersigned will assume full responsibility for any such action, including payment of costs.

I/we have completed an **Emergency Medical Release Form** for the above named minor, which includes all allergies, medicine reactions or unusual physical conditions, which should be made known to a treating physician.

_____ Date: _____
Parent/Guardian Signature

_____ Date: _____
Parent/Guardian Signature

Emergency Medical Release Form

I, _____, parent/legal guardian of

_____,do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of 9B Trails Crew should for whatever reason I am not reasonably available by telephone to give consent.

This authorization is effective from the ___ day of _____, 20_____.

_____ _____
Signature of Parent or Legal Guardian Date

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address: _____

Father's phone: _____ Mother's phone: _____

Last Tetanus: _____

Any Allergies? _____

Special Medications, Blood Type or Pertinent Information: _____

_____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy # _____