WEBSTER CONFERENCE CENTER, INC.
CHALLENGE COURSE AGREEMENT
Agreement to Participate, Assumption of Risk and Release of Liability

Whereas, I the undersigned wish to participate on the Challenge Course of Webster Conference Center of Salina, Kansas, I acknowledge that during the activities I will participate, there will be a certain amount of risks and danger. These include, but are not limited to, depending on other people and being at various heights (ground to 35'), and accidents. I recognize that these risks may also include loss or damage to personal property, physical or psychological damage and/or injury.

I certify that I am completely healthy (both physically and emotionally) and capable of participating in this activity. My health form is current and accurate, and I understand it is solely my responsibility to determine where there is any medical reason that I should not participate. I also state that I am not under the influence of any chemical substance including alcohol.

I have and do hereby assume all the above risks and any other ordinary risk incidental to the activity that are not specifically foreseeable, and will hold Webster Conference Center, Inc., its Directors, Officers, Employees, Agents, and/or Associates harmless from any and all liability, actions, causes of action, debts, claims and demands of every kind and nature whatsoever, whether for bodily injury, property damage or loss. In short, I will not sue Webster Conference Center, Inc., its Directors, Officers, Employees, Agents, and/or Associates. This is binding on me, my executors, heirs and next of kin, successors and assigns, or anyone else who might sue or claim on my behalf. I also understand that my physical activity involves risk of injury, and I have entered into this activity voluntarily and take full responsibility for my decision to participate or not to participate and I agree to follow all safety instructions.

Name of Participant: *(Please Print)* _____ **Date:**

Address _____

City/State/Zip _____

Birthdate ____/____/____ **Age**_____ **City, Church Name** _____

Signature of Participant: _____

Approval Signature of Parent/Guardian

if Participant is under 18: _____

Address _____
(If different from above)

City/State/Zip _____

Employed by _____

Daytime Phone (____)_____ **Evening/Night Phone** (____)_____

Name of Physician: _____ **City** _____ **State** _____

Physician's Phone Number (_____)_____

— OVER —

MEDICAL INFORMATION

Do you frequently suffer from pains in your chest? □ **YES** □ **NO**

Do you often feel faint or have spells of severe dizziness? □ **YES** □ **NO**

Has a doctor ever told you that you have high blood pressure? □ **YES** □ **NO**

Are you currently sick and/or using a medication not listed elsewhere on this form? □ **YES** □ **NO**

Have you had any operations or serious injuries in the last three months? □ **YES** □ **NO**

Do you have arthritis, joint or back problems that might be aggravated by exercise? □ **YES** □ **NO**

Are you currently taking medicine or treatment? □ **YES** □ **NO**

If yes, explain _____

Have you been restricted from sports or swimming for any reason? □ **YES** □ **NO**

If yes, explain _____

Date of last Tetanus shot: _____ **Date of last physical exam** _____

Have you ever had a severe reaction to a bee/hornet sting, or insect bite? □ **YES** □ **NO**

If yes, explain _____

Do you have:

- □ **Sinus Trouble**
- □ **Hay Fever**
- □ **Heart Trouble**
- □ **Epilepsy**
- □ **Asthma**
- □ **Diabetes**
- □ **Communicable diseases? If yes, please explain** _____

_____

List any Allergies:

Food _____

_____

Drugs _____

_____

Other Medical Needs: _____

_____

EMERGENCY MEDICAL AUTHORIZATION

Event: CHALLENGE COURSE AT WEBSTER CONFERENCE CENTER

In the event of an emergency, I hereby give permission to any Webster Conference Center staff person, or their designee, who is present at the above mentioned event to obtain medical assistance. I also give permission to the Physician selected to hospitalize and secure proper treatment.

Parent/Guardian Signature _____

Insurance Company _____

Mailing Address to Submit Claims: _____

City: _____ **State:** **Zip:** _____

Policy Number _____

If I cannot be reached, please notify _____

(____) _____ or (____) _____

Today's Date _____