

**Application for Rangerette Summer Clinic
for Students 18 years old and older**

This form MUST be signed and notarized before the applicant is allowed to remain or participate.

Name _____ Grade (next year) _____ College _____

Address _____ School last attended _____

City/State/Zip _____ Date of Birth _____

Telephone (Home) _____ (Other) _____

T-shirt Size Youth Sizes S M L Adult Sizes S M L XL

Roommate 1st choice _____ Email Address _____

Camp I will be attending _____ Date of camp _____

Anyone registering after early registration will be assigned roommates without regard to request. Out-of-town campers must leave the residence hall at the close of camp.

For payment by credit card Discover, MasterCard, Visa, American Express (circle one)

3 Digit Code _____ Name on Card _____ Expiration Date _____

Card# _____ Signature _____

Return this information to Rangerettes Forever, Kilgore College, 1100 Broadway, Kilgore, TX 75662-3204 or phone 903/983-8182 or fax 903/983-8255. For additional questions email Sherry Ransom at sransom@kilgore.edu.

**KILGORE COLLEGE RANGERETTES FOREVER
RELEASE AND INDEMNITY AGREEMENT**

In consideration of Kilgore College (KC) and The Kilgore College Rangerettes Forever (RF) providing instruction to _____, the undersigned, whose address is _____ hereby **AGREES AS FOLLOWS:**

(1) The undersigned agrees to INDEMNIFY and HOLD HARMLESS KC and RF, and their officers, directors, and employees against ANY AND ALL CLAIMS, INCLUDING NEGLIGENT ACTS OR OMISSIONS (whether bodily injury, death or property claims), for conduct committed by its officers, agents, employees, or employees of contractors that arise out of or in connection with my participation or instruction in the Rangerette summer camp program, wheresoever such activity occurs.

(2) In so agreeing, the undersigned ASSUMES ALL RISKS AND WAIVES ALL CLAIMS against KC and RF, their officers, directors, and employees for any damage, loss or injury, with respect to my participation in the Rangerette summer camp program, or in any such matters.

Signature _____ Date _____

ATTACH A COPY OF THE INSURANCE CARD THAT YOU ARE COVERED UNDER

Kilgore College Rangerettes Forever Consent for Medical Treatment

Student's Name:

First _____ MI _____ Last _____

Parents' Names:

Father: First _____ MI _____ Last _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Day _____ Evening _____ Cell _____

E-Mail: _____

Mother: First _____ MI _____ Last _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Day _____ Evening _____ Cell _____

E-Mail: _____

Other:

Name: First _____ MI _____ Last _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Day _____ Evening _____ Cell _____

E-Mail: _____

If the student has any special medical conditions, please list those along with the name and phone number of the Specializing Physician to contact in case of an emergency. _____

KILGORE COLLEGE RANGERETTES FOREVER AUTHORIZATION

I, _____, do hereby acknowledge and declare that I am over 18 years of age and I have the authority to grant the permission and consent for medical treatment stated herein. I further declare that I have no known medical conditions which would prohibit or limit my participation in The Kilgore College Rangerettes Forever program.

I hereby authorize any representative of Kilgore College or The Kilgore College Rangerettes Forever to authorize and consent to any medical examination, treatment, surgery, and/or administration of drugs by qualified, licensed medical personnel on my behalf which may become necessary due to injury, illness or disease while participating in The Kilgore College Rangerettes Forever and associated activities.

I understand that:

(1) the persons identified above will be notified as soon as possible by Kilgore College of any injury, illness or disease requiring medical examination or treatment pursuant to this consent. Once notified, such person(s) will be solely responsible for any further consent to medical, surgical or drug treatment provided to me.

(2) all expenses of such care, examination and treatment will be paid by me or my insurance.

(3) it is my responsibility to advise Kilgore College, in writing, of my special medical needs, including, but not limited to: medical insurance information, known medical conditions, known drug allergies, and regular medication.

By: _____

STATE OF TEXAS, COUNTY OF _____, SUBSCRIBED AND SWORN TO before me by the said _____ on this the _____ day of _____, 200__, to certify which witness my hand and seal of office. Notary Public in and for The State of Texas.

My commission expires _____