

Rangerette Camp Liability Form

Under 18 years old

Please turn these forms in when you check in at camp

Name: _____
(Please Print)

Camp(s) I am attending:

_____ Middle School Camp; June 13-16, 2018

_____ High School Camp Session I; June 17-20, 2018

_____ High School Camp Session II, June 21-24, 2018

_____ Initial here if you DO NOT give Rangerette Camp permission to take photos and/or videos of you for promotional and presentation purposes. Names are not listed with photos.

KILGORE COLLEGE RANGERETTES FOREVER RELEASE AND INDEMNITY AGREEMENT

In consideration of Kilgore College (KC) and The Kilgore College Rangerettes Forever (RF) providing instruction to _____ (name of minor), the undersigned, _____ (parent, guardian or managing conservator), whose address is _____, hereby

AGREES, on behalf of the minor, 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 the Minor's participation or instruction in the Rangerette summer camp program, wherever 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 the Minor's participation in the Rangerette summer camp program, or in any such matters.

Check one _____ Parent _____ Guardian _____ Managing Conservator

Signature _____ Date _____

ATTACH A COPY OF THE MEDICAL INSURANCE CARD THE MINOR IS COVERED BY

Kilgore College Rangerettes Forever Consent for Medical Treatment of a Minor

Student's Name:

First _____ MI _____ Last _____

Parents**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:** _____ Managing Conservator _____ Guardian _____ Other Local Contact**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 these along with the name and phone number of the Specializing Physician to contact in case of an emergency.

KILGORE COLLEGE RANGERETTES FOREVER AUTHORIZATION

I, _____ the natural parent, legal guardian or managing conservator of _____, a minor, do hereby acknowledge and declare that said minor is presently under my care, custody and control and that I have the authority to grant the permission and consent for medical treatment stated herein. I further declare that the minor has no known medical conditions which would prohibit or limit his/her 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 and for said minor 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) I 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, I will be solely responsible for any further consent to medical, surgical or drug treatment provided to said minor.
- (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 any special medical needs of said minor, including, but not limited to: medical insurance information, known medical conditions, known drug allergies, and regular medication.

By: _____ Relation to Minor: _____

STATE OF TEXAS, COUNTY OF _____, SUBSCRIBED AND SWORN TO before me by the said _____ on this the _____ day of _____, 20____, to certify which witness my hand and seal of office. Notary Public in and for the State of Texas.

My commission expires _____