ASPENDALE BAPTIST ENCAMPMENT, INC.
PARTICIPANT ASSUMPTION OF RISK, RELEASE AND AGREEMENT FOR HIGH RISK RECREATION ACTIVITIES

In consideration of the services of **Aspendale Baptist Encampment**, their agents, owners, officers, volunteers, participants, employees, and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as **ABE),** I hereby agree to release, indemnify and discharge **ABE** on behalf of myself, my children, my parents, my heirs, assigns, personal representative and estate as follows:

1. I acknowledge that my participation in "High Risk Recreation Activities" including ropes course, paint ball, go-carts, the archery/pellet ranges, and snow tubing, entails known and unanticipated risks, which could result in physical or emotional injury, paralysis, death, or damage to myself, to property, or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity.

ABE programs are based on the "challenge by choice" principle. At any time, you and/or your group are free to withdraw from participation in the high risk activities. **The risks include, among other things, the potential for:**

a) slips, falls and falling;
b) rope burns;
c) inches, scrapes, twists and jolts that could result in scratches, bruises, sprains, lacerations, fractures, concussions, or even more severe life-threatening hazards;
d) potential contact with plants, animals or insects that could create hazards such as stings, allergies, and associated diseases.

Furthermore**, ABE** instructors have difficult jobs to perform. They seek safety, but they are not infallible. They might be unaware of a participant's fitness or abilities, they might misjudge the weather.

2. I expressly agree and promise to accept and assume all of the risks existing in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.

3. I hereby voluntarily release, forever discharge and agree to indemnify and hold harmless **ABE** from any and all claims, demands, or causes of action, which are in any way connected with my participation in this activity or my use of **ABE** equipment or facilities, including any such claims which allege negligent acts of omissions or **ABE**.

4. Should **ABE** or anyone acting on their behalf be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

5. I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating, or else I agree to bear the costs of such injury or damage myself. I further certify that I am willing to assume the risk of any medical or physical condition I may have.

6. In the event that I file a lawsuit against **ABE**, I agree to do so solely in the state of *New Mexico*, and I further agree that the substantive law of that state shall apply in that action without regard to the conflict of the law rules of that state. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.

By signing this document, I acknowledge that if anyone is hurt or property is damaged during my participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against ABE on the basis of any claim from which I have released them herein.

I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms.

Signature of Participant_____ Print Name_____

Address_____

Phone_____ Date_____

PARENT'S OR GUARDIAN'S ADDITIONAL INDEMNIFICATION
(Must be completed for participants under the age of 18)

In consideration of _____(print minor"s name) ("Minor") being permitted by ABE to participate in its activities and to use its equipment and facilities, I further agree to indemnify and hold harmless ABE from any and all claims which are brought by or on behalf of Minor, and which are in any way connected with such use or participation by Minor. I further give my permission for said minor to participate in this activity.

Parent or Guardian_____ Print Name_____ Date_____

Reset Print

Please Print

Name: _____ Age: _____ Church: _____

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APPENDIX B

****This form is intended to remind staff and participants of the seriousness of attempting adventure activities with a pre-existing medication condition. This information is to be confidential.****

Question: Response: circle one

1. Any pre-existing medical conditions? Yes No
   If yes, please explain: _____
2. Are you currently taking any prescription or non-prescription medication? Yes No
   If yes, please explain: _____
3. Do you have a heart condition? Yes No
4. Do you have high blood pressure? Yes No
5. Do you have any allergies (food, bees, insects or medicines)? Yes No
6. Do you foresee any problems participating in the upcoming Odyssey Yes No
   Activity due to a lack of physical exercise back home? Yes No
   If yes, please explain: _____
7. Do you feel any pressure or coercion from others to participate? Yes No
8. Do you have a disability? Yes No
   If yes, please indicate the functional implications and any concerns about participation related to the disability:
   _____
   _____
   _____
9. Describe your current level of activity:
   _____
   _____

In case of emergency, contact _____Phone_____
Medical Insurance (company and policy number)
_____

Participant – please read and sign:

I have honestly disclosed to the staff any medical, psychological, or personal information relating to my health. I will remember that a Challenge by Choice© atmosphere exists at all times, and I should not feel pressured to participate.

_____ _____
Participant's Signature Date

*****You may use the back of this form to continue your answers or additional information******

NEW MEXICO FFA

PERSONAL LIABILITY RELEASE
MEDICAL INFORMATION
DELEGATE CONDUCT GUIDELINES
SPONSOR DELEGATION

Name of Student _____ Age _____
School _____ School Phone _____
Conference _____ City/State _____
Dates _____

MEDICAL INFORMATION

Student _____	Guardian _____
Spouse (if married) _____	Address _____
Home Address _____	_____
_____	
Phone:	Phone:
Work _____	Work _____
Home _____	Home _____
Student's Doctor _____	Alternate Contact _____
Address _____	Address _____
_____	_____
Phone:	Phone:
Work _____	Work _____
Home _____	Home _____

Please describe completely any medical condition (past or present) being treated which may recur or be a factor in medical treatment (include allergies, medicine reactions, disease of any kind, physical handicaps, heart or lung problems, seizures, convulsions, blackouts, etc). If currently taking medication - state the medication and prescribing physician and phone number:

We certify that the information described above is accurate and complete to the best of our knowledge. We understand that each individual is responsible for their own insurance coverage during this meeting or conference.

Name of Company _____ Policy # _____

SPONSOR DELEGATION

_____ School designates the adult(s) listed as the sponsor(s) who will supervise students during the Agriculture Education/FFA event.

OTHER ADULT SPONSORS: _____

_____

_____

_____

The New Mexico Agriculture Education Staff agrees to sponsor students from _____ school during an Agriculture Education/FFA event.

_____ (Signature)

School Official Title Date

SIGNATURES

Instructions: This form must be completed for each student attending a Agriculture Education/FFA event. Signatures acknowledge that all parties have read and concur with the information contained herein. Information concerning sponsor delegation shall be completed prior to affixing of signatures. PARENTS OF MINORS MUST ALSO **SIGN** THE MEDICAL FORM.

_____

State Staff Title Date

NOTARY

Instructions: Parent/Guardian - please check and sign ONE of the statements below.

_____ attending physician.
_____
treatment for my son/daughter.

_____ I DO NOT give permission for medical treatment until I have been contacted.

If, after I have been contacted, I consent to medical treatment --
_____ is the person authorized to grant permission for medical treatment for my son/daughter.

_____

Parent/Guardian Signature Date

STATE OF NEW MEXICO)
COUNTY OF _____) SS _____

Acknowledge before me this _____ day of _____ 20 _____

My commission expires:

_____ _____

(Notary Public)