



**FWCD ROPES CHALLENGE COURSE –
AGREEMENT TO PARTICIPATE AND RELEASE OF LIABILITY**

I, _____, wish to participate in the Fort Worth Country Day School (FWCD) Ropes Challenge Course (RCC) Program. I am aware that participating in the FWCD RCC Program brings inherent risk and dangers, and I recognize and assume all risks associated with such activity. It is my understanding that, and I have been informed that, there exists the possibility during participation of adverse health effects, including, but not limited to, abnormal breathing, abnormal blood pressure, fainting, dizziness, disorder of heart rhythm, and less likely, heart attack, stroke or even death. I also understand and have been informed that there exists the risk of bodily injury, including, but not limited to, injuries to the muscles, ligaments, tendons, bones, and joints of the body. I further understand that by participating, I may be exposed to the elements of nature, including temperature extremes, insects, wild animals, and inclement weather.

I understand that it is solely my responsibility to determine whether there is any medical reason that I should not participate in FWCD's RCC Program, and I certify that I am physically and emotionally capable of participating in FWCD's RCC Program. I understand that participation in the RCC Program may include, but is not limited to, balancing, bending, catching, climbing, jumping, kneeling, reaching, squatting, pulling, hanging, throwing, walking, etc. at heights from a few inches to 35 feet. I am fully aware of the risks and hazards connected with this activity, and I voluntarily assume full responsibility for any risks of loss, property damage, or personal injury, including death, that may be sustained by me, or any loss or damage to property owned by me, as a result of being engaged in such activity, whether caused by the negligence of FWCD or otherwise. I have listed on the Health History Statement any medical condition that FWCD should be aware of which may hinder my participation in RCC Activities. However, I understand that it is solely my responsibility to determine whether there is any medical reason that I should not participate in FWCD RCC Program.

In consideration of the right to participate in the FWCD RCC Program, **I hereby waive and release and agree to indemnify and hold harmless FWCD, its trustees, head of school, faculty, employees, and volunteers, together with all persons assisting with any activity of the RCC Program (collectively referred to as "releasees") from any and all claims, suits, losses, damages, causes of action, expenses of litigation and/or settlement, or other liability by reason of any accident or injury suffered, which may arise in connection with the FWCD RCC Program, whether or not caused by or alleged to be caused by the contractual negligence, negligence of FWCD or any releasee.** I further assume all responsibility and risks incidental to the nature of FWCD's RCC Program, including risks, which are not specifically foreseeable. I understand that FWCD will not be responsible for any medical costs associated with an injury I may sustain. I also understand that I am responsible for any damage I cause to FWCD's facilities or to the property of others.

I have carefully read this document and fully understand its content.

NAME OF PARTICIPANT (PLEASE PRINT)

SIGNATURE OF PARTICIPANT (18 YEARS AND OLDER)

511252

DATE OF SIGNATURE

FWCD ROPES CHALLENGE COURSE - HEALTH HISTORY STATEMENT



NAME (PLEASE PRINT)

BIRTH DATE (MM/DD/YY)

STREET ADDRESS

MALE / FEMALE
GENDER (CIRCLE ONE)

CITY, STATE, ZIP

INSURANCE COMPANY NAME

HOME PHONE

OTHER PHONE

INSURANCE POLICY NUMBER

IN CASE OF EMERGENCY, PLEASE NOTIFY

EMERGENCY PHONE NUMBER

HEALTH HISTORY (Circle appropriate answer as to whether it would impair your ability to participate in the FWCD Ropes Challenge Course and describe any YES answers).

Have you had or do you currently have any heart problems? _____ YES / NO

(If you have ever had any heart-related problems, you will need a release from a physician to participate on the high elements)

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 a smoker? _____ YES / NO

Do you have arthritis or back problems that might be aggravated by strenuous exercise? _____ YES / NO

Have you had any operations or serious injuries (dates)? _____ YES / NO

Do you have any disabilities or chronic recurring illness? _____ YES / NO

Are there any activities that are limited and/or discouraged by your physician? _____ YES / NO

Are you allergic to any medicines, insects, or pollen? _____ YES / NO

Do you have Epilepsy? _____ YES / NO

Do you have Diabetes? _____ YES / NO

Are you currently sick and/or using any medications? _____ YES / NO

REPRESENTATION AND EMERGENCY AUTHORIZATION

This Health History Statement is accurate so far as I know, and I believe that my health is satisfactory to participate in Ropes Challenge Course Activities. I hereby give permission to the medical personnel selected by Fort Worth Country Day School to order medical attention, including but not limited to, examination, injection, anesthesia and/or surgery for me. My authorization for emergency treatment shall also include, but not be limited to, my acceptance of charges incurred for the providing of aid and arranging transportation if necessary or desirable, at my sole cost and expense, whether self-pay or through my medical insurance.

SIGNATURE OF PARTICIPANT (18 YEARS OR OLDER)

DATE OF SIGNATURE