



GUEST CONSENT RELEASE FORM FOR SUMMIT TO SUMMIT RETREAT ATTENDEES

NOTE TO GUEST: Summit to Summit wants your experience at the men's retreat to be a safe and healthy one. However, in the event of an accident or illness, it is important that we have the following information.

Name Last First Middle Initial

Birthdate Age Sex

Spouse/First Emergency Contact Last First Middle Initial

Home Address Street and Number City State/Province Zip/Postal

Business Address Street and Number City State/Province Zip/Postal

Phone Number Home Business

Second Emergency Contact Last First Middle Initial

Home Address Street and Number City State/Province Zip/Postal

Business Address Street and Number City State/Province Zip/Postal

Phone Number Home Business

Any allergies or other medical needs?

Name of Physician Last First Middle Initial Phone Number

Address Street and Number City State/Province Zip/Postal

I have had a physical within the last 24 months.

Medical Insurance Company Policy Number

Address Street and Number City State/Province Zip/Postal

INDEMNITY AND CONTRACT AGREEMENT:

I will not hold or attempt to hold Summit to Summit liable for any loss, damage or injury to person or property caused by any act or neglect of other persons on or about the retreat, or caused in any manner other than the willful or negligent act of Summit to Summit, its agents and employees, and will indemnify and hold Summit to Summit harmless from any liability for damages or claims against Summit to Summit arising out of or in any way related to any such loss, damage or injury, including COVID related health risks associated with prolonged and close exposure to groups of people.

I release Summit to Summit, including its trustees, employees and agents, from my physical injury, including death, or illness while at the retreat. I will assume the risk associated therewith, whether known or unknown to me at this time. This release is also intended to include all claims of my family, estate, heirs, personal representatives or assigns.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to secure and administer treatment and to maintain and/or release any medical records necessary for insurance purposes as outlined under the HIPAA regulation, and to provide or arrange necessary related transportation for the above named person.

I verify that I am in good health and am capable of participating in strenuous activities, and when necessary, will tailor my activities to those within the bounds of my physical health. I recognize that any medical treatment that is provided to me while attending a Summit to Summit retreats will be paid for by my medical insurance company.

WAIVER AND RELEASE

IF I AM UNDER AGE 18, MY PARENT OR GUARDIAN, BY SIGNING BELOW, ALSO CONSENTS TO MY RELEASE AND HE OR SHE AGREES THAT THIS RELEASE SHALL BE BINDING UPON HIM OR HER AS MY PARENT OR GUARDIAN AS TO ME AND MY ESTATE, HEIRS, PERSONAL REPRESENTATIVES AND ASSIGNS. MY PARENT OR GUARDIAN ALSO PROMISES, BY SIGNING BELOW TO DEFEND, INDEMNIFY AND HOLD SUMMIT TO SUMMIT HARMLESS FROM ANY CLAIM ASSERTED BY ME AGAINST SUMMIT TO SUMMIT, INCLUDING ITS TRUSTEES, EMPLOYEES AND AGENTS, IF I SHOULD REPUDIATE THIS RELEASE AFTER OBTAINING ADULTHOOD.

Signature Date

Name of Your Group/Church Dates of Event