LONGVIEW INTERFAITH
HOSPITALITY NETWORK
700 N. Edith Longview, TX 75601
Phone: 903-234-8343 Fax: 903-234-1167

Cardboard Box City 2017

E-mail: info@longviewihn.com
www.longviewihn.com

Parent & Guardian Waiver
Event Date: November 10, 2017

Please print participant's information:

Name (last, first, middle): _____ Age _____ Birthdate____/____/____

Year in School: _____ Male _____ Female _____ Email: _____

Address: _____ Cell # ( ) _____

Mother's name _____ Home ( ) _____ Cell ( ) _____

Father's name _____ Home ( ) _____ Cell ( ) _____

Emergency Contact: _____ Relationship _____ Phone ( ) _____

Medical Insurance Company _____ Policy # _____

Medical History (asthma, diabetes, epilepsy, heart trouble) Allergies to food, drugs, bee stings, pollen, etc.

_____

Release and Indemnity Agreement

In consideration for facilitating my participation or my child's participation in the Cardboard Box City event on November 10-11, 2017, 6:00 p.m. – 8:00 a.m. at the lawn of St. Andrew Presbyterian Church (H.G. Mosley and McCann), I release Longview Interfaith Hospitality Network, St. Andrew Presbyterian Church and all of the officers, agents, volunteers, or employees of these three entities (collectively "LIHN and SAPC") from any and all claims and causes of action arising out of any loss or damage to me, my child, my property and any injury, including death, that I/he/she may sustain, **whether or not caused by the negligence of L.I.H.N. and SAPC** while participating in the above event.

I also agree to hold harmless, protect, and indemnify LIHN and SAPC from any and all claims, demands, or causes of action for property damage, personal injury, or death, including defense costs and attorney's fees, arising out of my/my child's participation in the above event, **regardless of whether such damages, injury, or death are caused by the negligence of L.I.H.N. and SAPC or the negligence of any other person or entity**.

In the event of injury to myself or my child, I further agree to give L.I.H.N. and SAPC permission to seek whatever medical attention is deemed necessary. In the event that the injury requires the attention of a medical provider, I consent to any reasonable medical treatment as deemed necessary by a medical professional. I also acknowledge that I will ultimately be responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I affirm that the above health insurance information provided by me is accurate and current.

(If participant is under 18 years old)
Child's Name _____
Parent Name _____ Parent Signature _____ Date _____

(If participant is over 18 years old)
Participant Name _____ Participant Signature _____ Date _____

Questions: Doris Ramaly (903)234-8343