Addison Fire District #1
Explorer Post #343

INFORMED CONSENT, RELEASE AGREEMENT, AND AUTHORIZATION

I understand that participation in Exploring activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or post advisors. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency, which renders me unable to verbally authorize treatment, permission is hereby given to the authorized Post Advisors and any qualified medical provider to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication that I may require. Medical providers are authorized to disclose protected health information to the adult in charge and/or any physician or health care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

With appreciation of the dangers and risks associated with programs and activities including preparations for and transportation to and from the activity, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, Addison Fire Protection District #1, Post Advisors, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

Participant

Name: _____ **Participant restrictions:** _____

Address: _____ _____

City, State, Zip: _____ _____

Date of Birth: _____

Participants Signature: _____ **Date:** _____

Health Ins. Info

Insurance Provider: _____ ID #: _____ Group #: _____

Policyholder Name: _____ DOB: _____