



THEMISSIONINC.ORG INFO@THEMISSIONINC.ORG 619.661.9232 PO BOX 360, POTRERO, CA 91963

PARTICIPATION FORM

PARTICIPATION, MEDICAL RELEASE, WAIVER & INDEMNITY AGREEMENT

I/We _____, have reviewed the information about RDSN Mexico's activities, events, and trips, and register myself as a participant **OR** give permission for the minor mentioned hereinafter to be involved in and participate in the overall activities. I register myself **OR** grant permission to mentioned minor with full knowledge that I accept full responsibility for any injury or accident that may occur.

I/We understand all reasonable safety precautions will be taken at all times by RDSN Mexico and its agents during the events and activities. I/We understand the possibility of unforeseen hazards and know the inherent possibility of risk. I/We agree not to hold RDSN Mexico, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by myself or mentioned minor.

I/We authorize any treatment by an accredited hospital and/or physician deemed necessary for myself or mentioned minor in case of an emergency. *The signature of the parent or guardian below is intended to serve as a medical release if the participant is a minor.*

I/We have reviewed the rules of the activities and agree that myself or mentioned minor will abide by them. I/We also acknowledge that if myself or mentioned minor, violates any rules resulting in expulsion from the event that any transportation and/or other costs will be at my expense.

By signing this document, I acknowledge that if anyone is hurt or property damaged by me or mentioned minor's participation in these activities, I or mentioned minor may be found by a court of law to have waived any right to maintain a lawsuit against RDSN Mexico on the basis of any claim that has been released herein. I/We have had sufficient opportunity to read this entire document. I have read and understood it, and agree to be bound by its terms.

CONTINUED ON REVERSE

This document shall remain in effect for one full year from date indicated, or until revoked in writing.

Participant Name _____

Participant Signature _____ Date _____

Address/City/Zip _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Date of Birth _____ Health/Med. Ins. Co. _____ Policy Number _____

(FOR MINOR PARTICIPANTS)

Parent/Guardian 1 Name (if aforementioned is minor) _____

Parent/Guardian 1 Signature _____ Date _____

Parent/Guardian 1 Address/City/Country _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Parent/Guardian 1 E-mail _____

Parent/Guardian 2 Name (if aforementioned is minor) _____

Parent/Guardian 2 Signature _____ Date _____

Parent/Guardian 2 Address/City/Country _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Parent/Guardian 2 E-mail _____

Please note that we will use as a reference for allergies, medical conditions, prescriptions and parental contact any information and notes contained herein.

Additional Details:

