



Adult Recreation Programs

Release, Indemnification & Medical Form

(For Participants 18 Years of Age & Older)

Name of Class: _____ (Class)

I understand that participation in the Class involves inherent risk and possible injury because of the nature of the activities, even when conducted in a safe manner, and I hereby assume all responsibility for my safety when participating in the Class (including virtual and online offerings). Injuries to participants in active recreation programs may occur from risks inherent in the activity; from placing stress on the body that it has not been prepared for; from accidents in learning or practicing techniques; from failing to follow training, safety or program rules; from the use of transportation associated with the activity; and from the administration of first aid. The severity of injury can range from minor cuts, scrapes, or muscle strains to catastrophic injury such as paralysis or even death.

I also understand that participation in the Class involves risk of exposure to and infection by the novel coronavirus, COVID-19, which is highly contagious and spread through person-to-person contact (breath and physical contact) and contact with stable surfaces. I understand that exposure and infection can result from the actions and/or omissions of me, other participants in the Class, and Bainbridge Island Metropolitan Park and Recreation District (BIMPRD) employees, agents and contractors, and that infection could result in illness, bodily injury, permanent disability and/or death. Although BIMPRD has implemented preventive measures, such as participant screening, social distancing and sanitizing surfaces, to reduce the spread of COVID-19, risk of exposure and infection cannot be eliminated entirely. I hereby knowingly and voluntarily assume the risk of exposure to and infection by COVID-19 by participating in the Class.

In consideration for my acceptance as a participant in the Class, I hereby agree: to assume the risks of the activities in which I participate in the Class; to waive and forever release BIMPRD and its employees, agents and contractors from any and all claims (including those for illness and bodily injury) arising out of or relating in any way whatsoever to my participation in the Class, even though said claims may arise out of the negligence of BIMPRD and its employees, agents and contractors; to limit BIMPRD's liability to the applicable limits of BIMPRD's applicable insurance policy if the foregoing waiver and release is deemed unenforceable; to defend, indemnify and hold BIMPRD and its employees, agents and contractors harmless from and against any and all claims (including those for illness and bodily injury), losses, damages, liabilities and expenses (including attorney fees) arising out of or relating in any way to my participation in the Class, my failure to comply with the obligations under this document, or my failure to provide all relevant medical information.

I authorize provision of emergency medical care to me if needed during participation in the Class when efforts to contact the emergency contact are unsuccessful, and I agree to be financially responsible for all costs thereof. I agree that the waiver and release, limitation of liability, and indemnification provisions of the foregoing paragraph shall apply to any provision of medical care. I represent and warrant that the information I provide on page 2 of this document fully and accurately sets forth all medical information that is relevant to my participation in the Class. I agree to inform BIMPRD as soon as possible hereafter if I test positive for COVID-19 before and while participating in the Class.

I give BIMPRD permission to photograph and videotape me while participating in the Class. I authorize BIMPRD to use such photographs and videotapes to promote its programs and classes, and I waive any and all claims to compensation for such usage. I acknowledge and agree that all such photographs and videotapes will belong to BIMPRD.

I agree that this document shall be binding upon my heirs, representatives, successors and assigns. I understand and agree that this document is intended to be as broad and inclusive as is permitted by the laws of the State of Washington, and that if any portion of it is deemed unenforceable, the balance of it shall continue in full legal force and effect.

I agree that if my signature is provided to the District via electronic means (e-mail, fax or otherwise), it shall nonetheless be deemed the equivalent of my original signature for all purposes.

I AM VOLUNTARILY SIGNING THIS DOCUMENT WITH THE INTENT PROSPECTIVELY TO RELEASE AND INDEMNIFY BIMPRD AND ITS EMPLOYEES, AGENTS AND CONTRACTORS AS SET FORTH ABOVE. I HAVE READ THIS DOCUMENT AND FULLY UNDERSTAND AND ACKNOWLEDGE THAT BY SIGNING IT I AM GIVING UP IMPORTANT LEGAL RIGHTS.

Name of Participant: _____ Signature: _____ Date: _____
(Print)

Home Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____

EMERGENCY & MEDICAL INFORMATION

Emergency Contact Information

Name: _____ Home Phone: _____
(Print)
Cell Phone: _____ Work Phone: _____ Email: _____

Medical Information for Participant

Health Insurance Carrier: _____ ID #: _____

Primary Physician: _____ Location: _____

Illnesses/Conditions: _____

Medications (Needed for, dosage): _____

Food allergies (How severe?): _____

Other allergies (How severe?): _____ Carry Epi-Kit? _____

Asthma (Triggers?): _____ Carry Inhaler? _____

Heat-related problems (How severe?): _____

Glasses? _____ Contacts? _____ Braces? _____ Retainer? _____

Have you tested positive for COVID-19? _____ If yes, what was the date of the test? _____

Are you currently experiencing any of the following symptoms (circle all that apply): shortness of breath difficulty breathing
fever chills cough loss of taste or smell fatigue muscle or body aches headaches sore throat

Describe previous muscular, skeletal, head, neck, or back injury (Limitations?): _____

Any other information for staff to be aware of that may affect participation: _____

BIMPRD reserves the right to require written clearance from a health care provider before allowing a person to participate in a certain activity.

Participant Initials