Student Full Name _____ Date _____

STUDENT WAIVER INDEMNIFICATION AND MEDICAL TREATMENT AUTHORIZATION FORM

1. EXCULPATORY CLAUSE. In consideration for receiving permission to participate in any and all activities of EAGLE VIEW SECURITY EXPLORER 2022, which is sponsored by EAGLE VIEW SECURITY & INVESTGATION SERVICES INC., I hereby release, waive, discharge, covenant not to sue, and agree to hold harmless for any and all purposes, The Eagle View System, and their members, officers, servants, agents, volunteers, or employees (herein referred to as RELEASEES or INDEMNITEES) from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while participating in such activity, while traveling to and from the activity, or while on the premises owned or leased by RELEASEES, including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of REALESEES. I understand this waiver does not apply to injuries caused by intentional or grossly negligent conduct.

2. INDEMNITY CLAUSE. I am fully aware that there are inherent risks to myself and others involved with this activity, including but not limited to _____, and I choose to voluntarily participate in said activity with full knowledge that the activity may be hazardous to me and my property, and to the person and property of others. I acknowledge there may be physically strenuous activities. I know of no medical reason why I should not participate. I agree to indemnify and hold harmless INDEMNITEES from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, which may occur to myself, other participants, and third-persons as a result of my participation in said activity, including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of INDEMNITEES.

3. NO INSURANCE. I understand that RELEASEES may or may not maintain any insurance policy covering any circumstance arising from my participation in this activity or any event related to that participation. As such, I am aware that I should review my personal insurance coverage. Organization may not carry general liability insurance to cover claims arising from this activity so it seeks a waiver of claims as additional consideration for the right to and provide access to a greater number of participants by expending limited resources on program rather that liability insurance.

4. BIND HEIRS. It is my express intent that this agreement shall bind the members of family and spouse, if I am alive, and my heirs, assigns and personal representatives, if I am deceased, and shall be governed by the laws of the State of Texas.

5. MEDICAL AUTHORIZATION, INDEMNITY FOR MEDICAL EXPENSES, and WAIVER. I understand RELEASEES cannot be expected to control all the risks articulated by this form and RELEASEES may need to respond to accidents and potential emergency situations. Therefore, I hereby give my consent for any medical treatment that may be required, as determined by a medical professional at the medical facility, during my participation in this activity with the understanding that the cost of any such treatment will be my responsibility. I agree to indemnify and hold harmless IDEMNITEES for any costs incurred to treat me, even if an INDEMNITEE has signed hospital documentation promising to pay for the treatment due to my inability to sign the documentation. I further agree to release, waive, discharge, covenant not to sue, and agree to hold harmless for any and all purposes, RELEASEES from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while receiving medical care or in deciding to seek medical care, including while traveling to and from a medical care facility, including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of RELEASEES. I understand this waiver does not apply to injuries caused by intentional or grossly negligent conduct.

6. VOLUNTARY SIGNATURE. In signing this agreement I acknowledge and represent that I have read it, understand it, and sign it voluntarily as my own free act and deed; organization has not made and I have not relied on any oral representations, statements, or inducements apart from the terms contained in the agreement. I execute this document for full, adequate and complete consideration fully intending to be bound by the same, now and in the future.

SIGNING THIS DOCUMENT INVOLVES THE WAIVER OF VALUABLE LEGAL RIGHTS. CONSULT YOUR ATTORNEY BEFORE SIGNING THIS DOCUMENT.

SIGNED this _____ day of _____, 20_____.

Participant Signature: _____

Printed Name: _____

Participant's Date of Birth: _____

Parent or Legal Guardian Signature: _____

Parent or Legal Guardian Printed Name: _____

This document should remain on file for two years after the date of event.

EAGLE VIEW SECURITY & INVESTIGATIONS SERVICES
&
Eagle View Explorers Post 2022

In case of emergency, contact _____
at the following number _____

Health Insurance Company Name _____
Policy Number _____

Automobile Insurance Company Name _____
Policy Number _____

Please list any special services you may require due to an existing medical condition or physical disability: _____

6826 Springfield Avenue, Suite 204A, Laredo, Texas 78041 Phone: (956) 726-5337

APPLICATION FOR REGISTRATION

A NON-REFUNDABLE $50 REGISTRATION FEE MUST ACCOMPANY EACH APPLICATION

Student Full Name: Nickname:

Date of Birth: / / Place of Birth: Campus: Grade:

Mailing Address: E-mail Address:

Is the child a US Citizen? Does the child live with parents? If not, then with who?

PARENT or GUARDIAN INFORMATION

Parent or Guardian Name: Telephone:

Parent or Guardian Employer: Occupation:

EMERGENCY CONTACT INFORMATION (beside parents)

Name of Contact: Telephone: Relation:

Name of Contact: Telephone: Relation:

MEDICAL INFORMATION

Child's Doctor: Address: Telephone:

Print Name: _____ Signature: _____ Date:_____