Mounted Games Across America

Medical Release

Section 1: ASSUMPTION OF RISK AND WAIVER

I understand that there are inherent risks of serious injury or even death possible with equine activities. I hereby, intending to be legally bound, for myself, my heirs, and assigns, executors and administrators, waive and release forever any and all liability, and all claims for damages against The Mounted Games Across America, Inc. (MGAA), Board of Governors, Instructors, Administrators, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain associated with my child's voluntary participation in MGAA activities.

_____Date_____ _____Date_____

Original Signature of Competitor (if 18 yr. or older) **and** Original Signature of Parent(s) or Legal Guardian.

Section 2: MGAA MEDICAL INFORMATION AND TREATMENT RELEASE

In consideration of my/my child's participation in a Mounted Games Across America, Inc. (MGAA) activity, and the inherent risks of equine activity that may result in injury/harm requiring emergency medical treatment, I authorize the Mounted Games Across America, Inc., it successors or assigns, officials, officers, directors, employees, agents and/or volunteers to obtain and release to any MGAA activity personnel (including, but not limited to, organizers, instructors, test examiners, chaperons), and to any first aid and safety personnel, medical professionals, and treating medical facility, any information regarding my/my child's medical history, symptoms, treatment, exam results and/or diagnosis.

I HAVE READ THIS ENTIRE RELEASE AND AGREE TO IT:

_____Date_____ _____Date_____

Original Signature of Competitor (if 18 yr. or older) **and** Original Signature of Parent(s) or Legal Guardian.

RELATED INFORMATION

Member Name _____

Parent or Guardian: _____

Address: _____

City/State/Zip _____

Home phone: (_____)_____ Work phone: (_____)_____ Cell phone: (_____) _____

If Parent or Guardian is unavailable,

Contact: _____Phone: (_____)_____

Family Physician: _____Phone: (_____)_____

My child is allergic to: _____

Other medical conditions _____

My child takes the following medication(s):_____

_____for: _____

Child's date of birth (month, day, year):_____ Medical Insurance Company:_____

Policy Number(_____

*Note: Competitors are insured for emergency accident medical treatment under the MGAA Accident Plan. This coverage is in excess of valid and collectible benefits available under any Blue Cross or Blue Shield group plan, or any group, blanket or franchise insurance plan.

SPECIAL INSTRUCTIONS

As parent or guardian of the above named child, please attempt to contact me at the time of the accident or illness without postponing medical treatment.

Other:_____