

**WAVE OF LIFE/ESS/QUEST
MEDICAL RELEASE FORM**

Name: _____

Address: _____

Home Phone: _____ Business/work phone: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Pertinent medical information (allergies, diabetes, medicine sensitivities, etc.) and physician proscribed medications currently taking (please include psychiatric or mood modifying medications):

Name, address, and phone number of preferred or family physician (if none, state none):

I hereby agree to participate in Wave of Life/ESS/Quest training programs. I do hereby acknowledge that such participation is wholly voluntary and may present unknown risks. I agree to assume all liability for risks associated with such participation. I hold harmless, and forever discharge the sponsor, its agents, servants, employees, and volunteers from any and all possible claims for damages or other harm to person or property, regardless of the manner by which any such claim may be brought. I accept the terms of this complete and total release and agree to be bound by it of my own free will, with full and complete understanding of its terms.

I hereby consent to emergency first aid, emergency medical care, and authorize, if necessary, admission to a hospital for treatment of injuries that I could sustain while participating in the program, I acknowledge that I shall be solely responsible for any incurred medical expenses. In absence of signature, payment of fees and/or participation in the program shall constitute acceptance of the conditions set forth in this release.

I further agree that any claim or dispute arising from or related to this agreement shall be settled by mediation pursuant to 1 Corinthians 6:1-8, if necessary, legally binding arbitration, pursuant to RCW 7.04.010 et seq. as amended, and in accordance with the rules of the Institute for Christian Conciliation, 1537 Ave. D, Billings, MT 59102.

Signature: _____ Date: _____