Eagle's Wings Retreat Center
2805 Ranch Rd.
Burnet, TX 78611
Parent/Guardian Medical Liability & Photography Release Form

Dear Parent or Guardian,

We are happy that your son/daughter will be participating in the activities at Eagle's Wings Retreat Center (EWRC). For our records and for any possible emergencies that might arise while at the retreat center, we ask that you fill out and sign this form and this will act as a Medical and Liability Release. Please note that your signature is required in two (2) places. Please be sure all information is correct.

Participant Information

Name_____BirthDate_____
Address_____ City/St._____Zip_____
Phone #_____Cell#_____

Mother's Name_____Father's Name_____
Mother's Address(if different than child)_____
Father's Address(if different than child)_____
Mother's Phone_____Father's Phone_____
(if different than child) (if different than child)
Email address of one parent _____

Parent/Guardian Permission

I hereby consent to participation by my son/daughter_____in the activities at EWRC. I give permission for my child to be evaluated, diagnosed, treated, and/or given medication in accordance with standard medical practice. I relieve EWRC, its staff, Board members and volunteers of all responsibility and consequence that may arise as a result of this treatment. I will not hold Eagle's Wings Retreat Center, Inc., its personnel, or volunteers liable in the event of injury. Further, I agree to accept financial responsibility as a result of scheduling medical treatment.

I also authorize Eagle's Wings Retreat Center the right use contact information and to photograph and use said photographs in any medium or form of distribution and for any purpose whatsoever, including, without limitation, all promotional and advertising uses.

My child agrees to abide by all rules and regulations stated by EWRC, staff and volunteers. I understand that EWRC will not be liable if my child fails to cooperate with regulations, and that any infraction of the rules may result in immediate dismissal from this facility at my expense.

Signature_____Date_____
Participant"s Signature_____

Medical and Emergency Information

Family Physician_____Phone (___)_____
Preferred Hospital_____City_____Phone(___)_____
Allergies_____Current Medications_____
Medical Condition we should be aware of_____
In case of emergency, please contact (If different from above)
Name_____ Phone_____
Name_____ Phone_____

_____ Opt-out: Please exclude my contact information from any solicitation (if left unchecked we assume you are ok with us contacting you from time to time via email or newsletters)