

For Office Use Only  
Date Received: \_\_\_/\_\_\_/\_\_\_  
Received By: \_\_\_\_\_  
Paid: CASH CHECK  
Amount: \$\_\_\_\_\_  
Jersey Size: YS YM YL AS AM

**TOWN OF WEST YELLOWSTONE PARKS AND RECREATION  
AGREEMENT TO PARTICIPATE AND RELEASE FORM**

\_\_\_\_\_ has permission to participate in the West Yellowstone  
Parks and Recreation 2010 Smokey Waters Day Camp.

**Agreement to Participate Statement**

I am aware that participating in the above program can be a dangerous activity involving **RISK OF INJURY**, including but not limited to:

**Sprains, strain, fractures and broken bones, bumps, bruises, contusions, burns, bites and weather related injuries.**

Because of the danger of participating in this program, I recognize the importance of following the instructors' instructions regarding techniques, rules, and precautions. I hereby agree to follow and/or reinforce those instructions.

I hereby voluntarily and expressly assume all risks associated with participation in the above program and agree to exonerate and save harmless the Town of West Yellowstone, its volunteers, servants, employees and trip leaders from any and all liability, claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connection to participation in the above program.

**The terms of this agreement shall serve as a release and my assumption of the risk shall be binding on my heirs, estate, executor, administrator, assigns and all of my family members.**

Solely the laws of the State of Montana shall govern this agreement and any matter in any way related to participation in the above program.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Participant's Printed Name

\_\_\_\_\_  
Participants Signature (if a minor)

\_\_\_\_\_  
Guardian's Signature (if participant is a minor)

As a parent or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, or cause disfigurement, physical impairment, or undue discomfort if delayed. The authority is granted only after a reasonable effort has been made to reach me.

**This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.**

Dates when release is intended \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Father/mother/legal guardian)

Physical Address \_\_\_\_\_ P.O. BOX # \_\_\_\_\_  
Home \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_  
Email \_\_\_\_\_

Other contact in case of emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

Family physician \_\_\_\_\_ Phone \_\_\_\_\_

Presently under the following medication \_\_\_\_\_  
\_\_\_\_\_

My child is covered under medical insurance    Yes    No

Please list any physical impairments and/or allergies that we should know about\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

AGE \_\_\_\_\_      BIRTHDAY \_\_\_\_\_