PARTICIPANT INFORMATION

I am interested in attending or learning more about the following activities (please check all that apply):

❑ HAFriends ❑ Weekly Dances ❑ Theater ❑ Ft Ben Day ❑ 500 Parade
❑ Symphony on the Prairie ❑ Stonycreek Bonfire ❑ Other Special Events

Suggestions for activities or events you would like to see in the future:

____

PARTICIPANT LAST NAME __________________ **PARTICIPANT FIRST NAME** ________________

Date of Birth ____ / ____ /____ ❑ Male ❑ Female

Street Address ____

City/State/Zip ____

This address is: ❑ Family Home ❑ Individual's Home ❑ Supported Living Site ❑ Group Home

Participant Home Phone ________________________ Participant Cell Phone ___________________________

Participant E-mail ____

Description of Disability ____

Allergies ____

Important Medical History ____

____

Any history of seizures (if one occurred anytime in lifetime, please mark yes)? ❑ Yes ❑ No
If yes, please also fill out the attached seizure form.

Current Medications ____

____

If medications are required during any HAF activity, caregiver(s) must be in attendance. In the case of HAFriends, special arrangements must be made with the Program Director.

Other Important Information ____

HAF staff can administer the following over-the-counter medication(s) if requested:

❑ Tylenol ❑ Advil ❑ Aspirin ❑ Aleve ❑ Benadryl ❑ Pepto-Bismol

PRIMARY CAREGIVER(S): ❑ Family ❑ Agency

Name(s) ____

Address ____

City/State/Zip ____

Home Phone _________________ Cell Phone _________________ Work Phone _________________

Primary Caregiver E-Mail Address ____

EMERGENCY CONTACT (***if different from primary caregiver)***

Name & Relationship ____

Phone #1_______________________ ❑ Call ❑ Text

Phone #2_______________________ ❑ Call ❑ Text

PREFERRED MODE OF CONTACT
Please number according to preference with 1 being most preferred.

_____ Call _____________________________ _______________________
Name Number

_____ Text _____________________________ _______________________
Name Number

_____ Email _____________________________ _______________________
Name Email

PREFERRED DELIVERY OF HAF MAILINGS
Please check all that apply.

❑ Paper Mailing
❑ Send to Participant's Address ❑ Send to Primary Caregiver's Address
❑ Send to this address: ____
Name & Address

❑ Email
❑ Participant's Email ❑ Primary Caregiver's Email
❑ Send to this email: ____
Name & Email

BLANKET PERMISSION & EMERGENCY/MEDICAL RELEASE

I hereby give permission for the above-named individual to participate in *all* activities sponsored by the Hollis Adams Foundation, including transportation inherent with various activities, and to receive appropriate medical treatment. I agree that the Hollis Adams Foundation will be relieved of any liability for, or expense incurred with, any injury sustained or medical necessity. Permission will be effective until it is withdrawn in writing by this individual or his or her legal representative.

By signing below, I acknowledge that I have read the above waiver and agree to its terms.

Participant/Parent/Guardian Signature (Circle One)______________________________Date__________

_ _

SERVICES AT WILL

Hollis Adams Foundation is a private foundation and does not have the capacity to meet the needs of every individual with special needs. Therefore, the HAF Board of Directors has the sole discretion to refuse or discontinue services and exclude any person from participating in future HAF sponsored events if it has been determined that we cannot effectively meet their needs. HAF provides services at will and can discontinue services if the participant no longer meets HAF criteria.

By signing below, I acknowledge that I have read the above waiver and agree to its terms.

Participant/Parent/Guardian Signature (Circle One) _____________________________ Date__________

_ _

RECEIPT OF NEW PARTICIPANT PAPERWORK

I need the following materials before starting at HAF: Emergency Contact Information, HAF Waivers, Third Party Waivers, Medication Permission, Notice of Privacy Practices, Seizure Form, IndyGo Half Fare Application, and the Parent/Guardian/Caregiver Handbook. By signing below, I acknowledge that I have received all of these forms on the date indicated. I understand that these are for my records. I also have the right to ask questions about any of these documents at any time in the future.

By signing below, I acknowledge that I have read the above waiver and agree to its terms.

Participant/Parent/Guardian Signature (Circle One) _____________________________ Date__________

_ _

PHOTO RELEASE FORM

I hereby consent to and authorize the use and reproduction, in print or in electronic format including but not limited to use on the Hollis Adams Facebook Page and the official Hollis Adams website, by Hollis Adams Foundation (HAF) or anyone authorized by HAF, of any and all photographs or videos which have been taken during any HAF sponsored event for any publicity purpose, without compensation.

By signing below, I acknowledge that I have read the above waiver and agree to its terms.

Participant/Parent/Guardian Signature (Circle One) _____________________________ Date__________

Permission Form for Medication

Participant's Name: ____ Birthdate: ________________

If Hollis Adams Foundation is to assist with medication during HAFriends, all information below must be filled out and medication MUST be labeled by physician or pharmacist or be in original container.

May Hollis Adams Foundation provide over-the-counter medication if requested? **Yes** **No**

If Yes, check preferred medicine: ❑ Advil ❑ Tylenol ❑ Aspirin ❑ Aleve ❑ Benadryl ❑ Pepto-Bismol

Prescribed medication to be taken at HAFriends:

Disease, Illness, or Injury: ____

Medication:____

______ Daily ______PRN ______ Emergency

Dosage: ______________ Frequency: ____________ Time:____________

Route of delivery: ____

Side effects (from medication) participant should be observed for:_____________________________

____

Other medication(s) participant is taking: ____

____

May participant self-administer medication under the supervision of Hollis Adams Staff? **Yes** **No**

Directions for self-administration: ____

ASTHMA & ALLERGIES only:

Severity of asthma necessitates that participant carry inhaler on their person while at HAF **Yes** **No**

Severity of allergy necessitates that participant carry an Epi Pen on his/her person **Yes** **No**

Should an additional Epi pen be kept in the Program Director's office? **Yes** **No**

Additional instructions from physician: ____

Consent for above administration of medication:

____________________________________ ____________________________________

Participant/Parent/Guardian signature Emergency phone #

____

Date

Caregiver Waiver of Liability:

I herewith acknowledge that I am primarily responsible for administering medication to above named participant. However, in my absence, I hereby authorize Hollis Adams Foundation and its employees to assist with medication to participant the above noted medication. I further acknowledge and agree that when the above medication is given, I waive any claims I might have against Hollis Adams Foundation and its employees. In addition, I agree to hold harmless and indemnify the Hollis Adams Foundation and its employees, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from giving named medication.

________________________________ ________________________

Participant/Parent/Guardian Signature Date

Revised 7/1/16

Seizure Form

Name: ____ Date of last known seizure: ____________________

Description of Seizure (check all that apply):

Body: ❑ whole body ❑ right side ❑ left side ❑ other: _______________________________________

Movement: ❑ jerking ❑ stiffness ❑ jerking & stiffness ❑ other: ______________________________

Eyes: ❑ up ❑ closed ❑ right ❑ left ❑ stare ❑ stare & blink ❑ no change
❑ other: ____

Skin Color: ❑ blue ❑ no change ❑ other: ____

Emissions: ❑ urine ❑ fecal ❑ vomit ❑ none ❑ other: _____________________________________

Mouth: ❑ dry ❑ drool ❑ foam ❑ bite tongue ❑ other: _____________________________________

How Often: ❑ daily ❑ weekly ❑ monthly ❑ yearly ❑ randomly
❑ other: ____

After Seizure: ❑ asleep ❑ drowsy ❑ alert ❑ disoriented ❑ paralyzed ❑ aggressive
❑ other: ____

Triggers

____

____

Daily Seizure Medication

Medicine(s) and Dose(s): ____

Time(s) taken: ____

Seizure Treatments

Device Type: _________________________________ Date Implanted: _________________________________

Dietary Therapy: ______________________________ Date Begun: _____________________________________

Special Instructions: ____

Other Therapy: ____

PRN (as needed, NOT daily) Treatments

Name: ____

Amount to give: ____

When to give: ____

How to give: ____

Special Instructions

____

____

I acknowledge Hollis Adams Foundation staff will call 911 or seek emergency medical help if:

☑ seizure presents in an abnormal manner from stated above

☑ PRN treatments do NOT work

☑ injury occurs or is suspected, or seizure occurs in water

☑ breathing, heart rate, or behavior do not return to normal after 30 minutes

☑ unexplained fever or pain

☑ other reasons that cause staff concern

____ __________________________

Participant/Parent/Guardian/Caregiver Signature Date

Notice of Privacy Practices

1. GENERAL RULE - NO USE OR DISCLOSURE: Our office must not use or disclose protected health information (PHI), except as these Privacy Policies & Procedures permit or require.

2. ACKNOWLEDGMENT: Our office will make a good faith effort to obtain a written acknowledgment of receipt of our Notice of Privacy Practices from a participant or their representative before we use or disclose his or her PHI.

Indiana privacy law does not require signed Consent in addition to signed Acknowledgment.

3. AUTHORIZATION: In some cases we must have proper, written Authorization from the participant (or the participant's personal representative) before we use or disclose a participant's PHI for any purpose other than our healthcare operations.

Authorization Revocation - A participant may revoke an authorization at any time by written notice.

We will not disclose to a personal representative who we reasonably believe may be abusive to a participant any PHI we reasonably believe may promote or further such abuse.

Our office may use or disclose PHI in the following types of situations, provided procedures specified in the Privacy Rules are followed:

1. For public health activities;
2. To health oversight agencies;
3. To coroners, medical examiners, and funeral directors;
4. To employers regarding work-related illness or injury;
5. To the military;
6. To federal officials for lawful intelligence, counterintelligence, and national security activities;
7. To correctional institutions regarding inmates;
8. In response to a subpoena with participant permission or a court order;
9. To law enforcement officials;
10. To report abuse, neglect, exploitation, or domestic violence;
11. As required by law;
12. As authorized by state worker's compensation laws.

4. REQUIRED DISCLOSURES: Our office will disclose PHI to the U.S. Department of Health and Human Services (HHS) on request for complaint investigation or compliance review.

5. BUSINESS ASSOCIATES: Our office will obtain satisfactory assurance in the form of a written contract that our Business Associates will appropriately safeguard and limit their use and disclosure of the PHI we disclose to them.

Breach by Business Associate – If our office learns that a Business Associate has materially breached or violated its Business Associate Contract with us, we will take prompt, reasonable steps to see that the breach or violation is cured.

If the Business Associate does not promptly and effectively cure the breach of violation, we will terminate our contract with the Business Associate, or if contract termination is not feasible, report the Business Associate's breach or violation to the U.S. Department of Health and Human Services.

6. PARTICIPANT'S RIGHTS: Our office will honor the rights of participants regarding their PHI.

Access – With rare exceptions, our office must permit participants to request access to the PHI we or our Business Associates hold.

7. STAFF EDUCATION & MANAGEMENT AND COMPLAINT PROCEDURES:

Educating –Each staff member and employee will be advised of our policies and provided with a copy of these Policies & Procedures.

Discipline and Mitigation – Our office will develop, document, disseminate and implement an appropriate discipline policy for staff members who violate our Privacy Policies & Procedures, the Privacy Rules, or other applicable federal or state privacy law. Staff members and employees who fail to honor, or who violate these Policies & Procedures, are subject to disciplinary action up to and including termination.

Complaints - Our office will implement procedures for participants to complain about non-compliance with our Privacy Policies & Procedures or the Privacy Rules. We will also implement procedures to investigate and resolve such complaints. The Complaint form can be used by the participant to lodge the complaint. Each complaint received must be referred to management immediately for investigation and resolution. We will not retaliate against any participant or workforce member who files a complaint in good faith.

I acknowledge I have received and read the *Notices of Privacy Practices* for Hollis Adams Foundation.

____ (Signature)

___________________________ (Date)

____ (Printed Name)

Half Fare Identification Card Application

Part I – Applicant Information (Please print)

Name (last, first, middle initial)

____

Address ______________________________

City ______________ State ________ Zip ______________

Birth date (month, date, year)______________________________

Home phone (______)____________ E-mail address ______________________

Part II – Eligibility

Youth 18 and younger, senior citizens 65 and older and persons with disabilities as defined by the FTA (Federal Transit Authority) are eligible to apply for and receive half fare pricing for transit use.

Persons with a valid Medicare card need not apply for an IndyGo Half Fare ID. Medicare cardholders should display the Medicare card to the IndyGo bus operator when boarding to receive half fare benefits (see other side). If you have a valid Medicare card and would like to purchase an IndyGo Half Fare Identification Card, you need only to show your Medicare card and pay $2.

Please check your category:

- ☐ Youth - Proof of age is required. Expires on passengers 19th birthday.
- ☐ Senior – Proof of age is required. No expiration date
- ☑ Disabled – To qualify for a disabled classification, passenger will need to complete a separate form along with information from a physician or case worker who can validate disability. Valid for three years from card issue date.

Applicant Signature

____

Date of application

____

Updated Nov. 2009

NOTE: Half Fare ID cards are $2. Replacement cards cost $5 before expiration date.

IndyGo reserves the right to revoke an IndyGo Half Fare ID card for falsification of application or rider misconduct based on rider codes or unlawful activities.

Part III – For office use only

Approved by

____

Proof of Age documentation

____

All applications and supplemental documents are for IndyGo use only and will be filed in a secure place.

IndyGo (Indianapolis Public Transportation Corporation)
IndyGo Customer Service Retail Center
34 N Delaware Street
Indianapolis, IN 46204

317.635.3344

Half Fare Eligibility Statement:

Persons whose disability results in limited ability to use public transportation as defined by Federal Transit Authority (FTA) federal regulation 49CFR.609.3 which provides that disabled persons means those individuals who, by reason of illness, injury, age, congenital malfunction, or other permanent or temporary incapacity or disability, including those who are non-ambulatory wheelchair-bound and those with semi-ambulatory capabilities, are unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively as persons who are not so affected. The definition of elderly is all persons 65 and older. A Medicare card is also recognized for reduced fare.

If you have a Medicare card, you do not need to complete this application. The driver will recognize your Medicare card for half fare.

A temporary card cannot be issued for a disability of less than 90 days.

Please return completed application(s) in person to:
34 N Delaware Street
Indianapolis, IN 46204
317.635.3344

ID passes will be taken the day you return your paperwork. IndyGo reserves the right to verify information before issuing passes.

NOTE: Half Fare ID cards are valid for three years. After ID card expires, please resubmit application and supplemental application for recertification.

Half Fare Supplemental Application For

Please return this with your half fare application. Please print.

Name ______________________________

TO BE COMPLETED BY A PHYSICIAN OR AGENCY REPRESENTATIVE

The following classifications are not intended to be an exhaustive list, but those disabilities that will most likely result in limiting one's ability to use public transportation.

- ☐ The individual has any condition requiring the use of crutches, wheelchair, walker, leg or foot braces, or other such devices in order to be mobile.
- ☐ The individual has a missing limb or critical part thereof; use of prosthetic devices.
- ☐ The individual is blind or deaf. Legal blindness automatically qualifies. Legal blindness is one that has a visual acuity of 20/200 or less in the best corrected eye or a visual field of 20A or less in the best corrected eye.
- ☐ The individual has a musculo-skeletal condition that impairs motor skills to a severe extent, such as muscular dystrophy.
- ☑ The individual has a mental disability or psychological disorder which substantially limits one or more major life activities such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working.
- ☐ The individual has a temporary disability affecting mobility (lasting at least three months but no more than 12 months) which can be expected to last until

  (date) ______________________
- ☐ Other transportation disability. Please describe:

  ____

  ____

PLEASE NOTE: The physician or agency statement on this application must be completed and signed by a qualified physician or agency. **IndyGo reserves the right to require any applicant to provide additional information if needed to clarify or verify a disability. This additional research may take additional time, preventing same day ID issuing.**

Updated Nov. 2009

APPLICANT'S STATEMENT

I believe that based on the Half Fare Eligibility Statement (defined by 49CFR.609.), I am qualified to participate in IndyGo's reduced fare program. I understand that a physician or agency statement describing my disability and how it affects my mobility must be part of the application. I also understand that, if accepted, I will be issued only one reduced fare identification card at a cost of $2.00 I hereby authorize my physician or agency representative to release as necessary medical information to the IndyGo Transportation System regarding my condition.

Signature of Applicant ______________________________

Today's Date __________

IndyGo Indianapolis Public Transportation Corporation

IndyGo Customer Service Retail Center
34 N. Delaware Street
Indianapolis, IN 46204
317.635.3344

PHYSICIAN'S OR AGENCY'S STATEMENT (Please print)

Physician or Agency representative name
Kim Forester

Agency or Medical practice name
Hollis Adams Foundation

Address
2727 E. 55th street, #20512, Indianapolis, IN 46220

Phone
(317) 489-0100

Date
____

Please describe medical condition(s) of applicant:

____

____

____

I hereby certify in accordance with federal regulation 49CFR.609.3, ___________________
(Applicant's Name) in my opinion, qualifies for an IndyGo reduced fare identification card, because his/her disability requires special assistance, facilities, planning or design in order to ride IndyGo buses as effectively as persons who are not so affected.

I declare under the penalty of perjury that the statements on this application are true and correct to the best of my knowledge and belief.

Physician's or Agent's signature Kimberly Forster

Date _____________

In order to receive your photo ID Card; return this form with your application, in person, to the IndyGo Customer Service Center, 34 N. Delaware Street. For information call 635-3344. This program is subject to change by IndyGo. Public notice will be provided regarding any future changes. IndyGo will determine the eligibility of passengers for the half-fare program based upon information provided.

All information provided for half-fare certification process will be confidential and will not be provided to other agencies.

Unless a temporary pass is issued, your half-fare pass will be issued for a three year time period. At the end of the three-year period you will need to renew your application to remain eligible for half fare.

Half Fare Eligibility Statement:

Persons whose disability results in limited ability to use public transportation as defined by Federal Transit Authority (FTA) federal regulation 49CFR.609.3 which provides that disabled persons means those individuals who, by reason of illness, injury, age, congenital malfunction, or other permanent or temporary incapacity or disability, including those who are non-ambulatory wheelchair-bound and those with semi-ambulatory capabilities, are unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively as persons who are not so affected.

All certified and registered Open Door riders may show their current Open Door ID on any IndyGo Fixed Route and ride for free.

NOTE: Half Fare ID cards are valid for three years. After ID card expires, please resubmit application and supplemental application for recertification.

Hoosier Heights Indoor Climbing

9850 Mayflower Park Drive Carmel, IN 46032
Ph: 317.803.2175
www.hoosierheights.com

WAIVER & RELEASE OF LIABILITY

First Name ____ Middle Initial ____ Last Name ____ Phone Number (____) ____ Date of Birth ____ Age ____

Address ____ City ____ State ____ Zip ____ Gender: ☐Male ☐Female

E-mail address: ____

Do you have any medical conditions or are you allergic to any medications? ☐Yes ☐No Please List: ____

Emergency Contact Name ____ Relationship to Participant ____ Emergency Contact Phone Number (____) ____

How did you hear of our facility? ☐Advertisement ☐Coupon ☐Mobile Wall ☐Internet ☐Friend: ____ ☐Other: ____

GYM RULES (Subject to change without notice)

1. Everyone must check in at front desk upon arrival for each visit. If you have an address or phone number change, please let us know!
2. Buddy checks are mandatory: climber must check belayer's equipment; belayer must check climber's equipment.
3. Participants must be a minimum of 15 years of age in order to belay. Participants under 12 years of age must be accompanied by a parent/guardian.
4. Participants under 18 years of age must have this "Waiver & Release of Liability" form signed by a parent or legal guardian.
5. All climbers and belayers must be safety approved by Hoosier Heights staff prior to climbing or belaying.(Toprope, boulder, sport, etc.)
6. Hoosier Heights is a drug, tobacco, and alcohol free environment. Hoosier Heights is not responsible for lost, stolen or damaged items.
7. Foul language, horseplay, tumbling on landing surface, swinging on ropes, running, unruly conduct, are NOT allowed at Hoosier Heights.
8. Food and drinks are allowed in the party areas only, NOT IN CLIMBING OR BOULDERING AREAS!
9. Management has the right to suspend or terminate any participant's membership or pass for violation of any gym rules or for any conduct deemed inappropriate, disruptive or unsafe by staff. No refunds will be given for such suspension or termination.
10. No bouldering above head height! While bouldering, all participants must use crashpads and spotters.

RELEASE AND ASSUMPTION OF RISK: In consideration of being permitted to use the facilities of Hoosier Heights Indoor Rock Climbing Facility L.L.C., and mindful of the significant risks involved with the activities incidental thereto, I, for myself, my heirs, my estate and personal representative, do hereby release and discharge Hoosier Heights Indoor Rock Climbing Facility L.L.C. (hereinafter referred to as "Hoosier Heights") from any and all liability for injury that may result from my use of the facilities of Hoosier Heights Indoor Climbing, and I do hereby waive and relinquish any and all actions or causes of action for personal injury, property damage, or wrongful death occurring to myself arising as a result of the use of the facilities of Hoosier Heights or any activities incidental thereto, wherever or however such personal injury, property damage or wrongful death may occur, whether foreseen or unforeseen, and for whatever period said activities may continue. I agree that under no circumstances will I, my heirs, my estate or my personal representative present any claim for personal injury, property damage or wrongful death against Hoosier Heights or its employees, members, directors, officers, agents or assigns for any of said causes of actions, whether said causes of action shall arise by the negligence of any said person or otherwise.

It is the intention of the undersigned individual to exempt and relieve Hoosier Heights and its employees, members, directors, officers, agents and assigns from liability for any personal injury, property damage or wrongful death caused by negligence. This contract shall be legally binding upon me, my heirs, my estate, and my personal representative, as well as upon any and all other person authorized to act for me or on my behalf or on behalf of my heirs, my estate, or my personal representative.

ACKNOWLEDGMENT: I, the undersigned, acknowledge that I understand that there are significant elements of risk associated with the sport of rock climbing, including those activities that take place indoors. In addition I realize these risks also pertain to related activities such as bouldering, incidental weight training, team building, fitness training regimens and equipment purchased or rented at Hoosier Heights. I realize that those risks may include, but are not limited to, injuries resulting from falls, equipment failures, entanglements, falling or dropped items, or the negligence of other climbers, participants, belayers, spotters, employees, or other users of the facilities. I acknowledge that I understand that the above list is not inclusive of all possible risks associated with rock climbing or the use of the Hoosier Heights facilities and that other unknown and unanticipated risks may result in injury, illness, paralysis or death.

MEDICAL AUTHORIZATION: I agree, on behalf of myself and on behalf of any minor children for which I am responsible, to authorize any medical treatment deemed necessary in the event of any injury or illness while participating in the use of the Hoosier Heights facility and/or its equipment. I agree, on behalf of myself and on behalf of any minor children, for which I am responsible, to pay all cost of any rescue and/or medical services as may be incurred on my/our behalf.

PROMOTIONAL AUTHORIZATION: I agree, on behalf of myself and on behalf of any minor children for which I am responsible, that any film or photographs of me/us, as users of the Hoosier Heights facility taken by Hoosier Heights staff, photographers, and/or videographers utilized by Hoosier Heights, become the property of Hoosier Heights, and may be used for promotional or commercial purposes. Furthermore, I authorize Hoosier Heights to contact me and/or any minor child for which, I am responsible via telephone, e-mail, or standard mail with promotions and special events or programs.

I, THE UNDERSIGNED, ACKNOWLEDGE THAT I HAVE CAREFULLY READ THE ABOVE RELEASE OF LIABILITY AND FULLY UNDERSTAND ITS CONTENTS AND THAT I FULLY AGREE WITH ITS TERMS AND CONDITIONS. I UNDERSTAND THAT BY SIGNING THIS RELEASE OF LIABILITY I AM KNOWINGLY AND WILLINGLY AGREEING TO RELEASE HOOSIER HEIGHTS AND ITS EMPLOYEES MEMBERS, DIRECTORS, OFFICERS, AGENTS AND ASSIGNS OF THEIR LIABILITY FOR ANY PERSONAL INJURY, PROPERTY DAMAGE, OR WRONGFUL DEATH CAUSED BY THE NEGLIGENCE OF ANY SAID PERSON OR OTHERWISE.

Participant's Signature: ____ Date Signed: ____

FOR PARENTS/GUARDIANS OF PARTICIPANTS UNDER 18 YEARS OF AGE

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release as provided above, all the Releasees, and for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releasees from all liabilities incident to my minor child's involvement or participation in these programs as provided above, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES, to the fullest extent of the law.

Parent/Guardian's Signature: ____ Print Name: ____ Date: ____

(✓) Appropriate Guardianship: ☐ PARENT ☐ LEGAL GUARDIAN

nifs Physical Activity Readiness Questionnaire (PAR–Q)

Regular physical activity is fun and healthy, and very safe for most people. However, some people should check with their doctor before they start becoming much more physically active. If you are between the ages of 15 and 69, the PAR–Q will tell you if you should check with your doctor before you become much more physically active than you are now. If you are over 69 years of age, and you are not used to being very active, check with your doctor. Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: **Check YES or NO**.

	YES	NO
1. Has a doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?	❑	❑
2. Do you feel pain in your chest when you do physical activity?	❑	❑
3. In the past month, have you had chest pain when you were not performing any physical activity?	❑	❑
4. Do you lose your balance because of dizziness or do you ever lose consciousness?	❑	❑
5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?	❑	❑
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?	❑	❑
7. Do you know of any other reason why you should not do physical activity?	❑	❑

Did you say:

YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR–Q and which questions you answered "YES".

- You may be able to do any activity you want – as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

REVIEWER'S COMMENTS:

____

____

____

____

Signature and Acknowledgement:

____

Date

NO to all questions

If you answered NO honestly to all PAR–Q questions, you can be reasonably sure that you can:

- Start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- Take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively.

Delay becoming much more active:

- If you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; **or**
- If you are or may become pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Waiver, Release of Liability and Consent to Medical Attention

In Exchange for my being allowed to participate in the National Institute for Fitness and Sport's (the "Institute") programs and opportunities (the "Activity"), I, and if I am not yet 18 years old, my parent or legal guardian (individually and collectively referred to below in the first person singular) agree to be bound by each of the following:

1. **Obligation to Inspect Facilities and Equipment.** I agree that prior to participating in the Activity, I will inspect the facilities to be used. If I believe anything to be unsafe, I will immediately advise the Institute of such unsafe condition(s) and may decline to participate in the Activity.
2. **Identification of Risks.** I understand that participation in the Activity may involve risk of injury, disability and death and perhaps damage to property.
3. **Assumption of Risk.** I am physically and psychologically ready to participate in the Activity and assume all risks connected with my participation in the Activity. I am voluntarily participating in the activity and using equipment and machinery with knowledge of the dangers involved. I accept personal responsibility for any liability, injury, loss or damage in any way connected with my participation in the Activity.
4. **Status of the Institute.** I understand and represent that the Institute (including its affiliated organizations, directors, officers, sponsors, employees, agents, successors, and assigns) is not my physician and that the Activity does not constitute the provision of medical or health care services.
5. **Waiver and Release.** I release and discharge the Institute, Indiana University (the owner of the Institute's premises), and each of their affiliated organizations, directors, officers, sponsors, employees, agents, successors, and assigns from all claims for any liability, injury, loss, or damage in any way connected with my participation in the Activity, whether or not caused in whole or part by the negligence of any of the organizations or individuals mentioned above. I intend for this waiver and release to also apply to my relatives, personal representatives, heirs, beneficiaries, next of kin, and assigns who might pursue any legal action or claim for such liability, injury, loss or damage. I further intend that this waiver and release shall be effective indefinitely, including all renewals of membership or participation in other programs or opportunities of the Institute, and unless and until I provide written notification to the Institute to the contrary.
6. **Consent for email and photo/video release.** I hereby authorize and give my full consent to the Institute to copyright and/or publish any and all photographs, video and/or audio in which I appear while attending the Institute or Activity. I further agree to allow, without compensation, my likeness and/or name to appear, and to otherwise be used, in material, regardless of media form, promoting the Institute, and/or its events and activities. I agree to receive direct e-mail communication from the Institute (If I do not wish to receive e-mail from the Institute, I can remove myself from the mailing list by clicking 'Unsubscribe' within the emails I receive at any time.)
7. **Consent to Medical Treatment.** I agree that the Institute (including its affiliated organizations, directors, officers, sponsors, employees, agents, successors, and assigns) may, but has no duty to provide me, through medical personnel of their choice, customary medical or training assistance, transportation, and emergency medical services.
8. **Applicable Law and Venue.** This waiver, release, and consent shall be governed, construed, and enforced in accordance with the substantive law of the State of Indiana. Any action with respect to this document or the Activity shall be brought in or venued to a court of competent jurisdiction (or other dispute resolution process) sitting in Marion County, Indiana.
9. **Severability.** If any provision (or portion of any provision) of this waiver, release, and consent is held to be invalid or unenforceable, that provision shall be enforceable in part to the fullest extent permitted by law, and such invalidity or unenforceability shall not otherwise affect any other provision of this instrument.

I have read this waiver, release and consent and understand that I have given up substantial rights by signing it. I am signing this Waiver, Release and Consent voluntarily.

Signature

Printed Name Date

Witness Signature Date

If the person participating in the Activity is not yet 18 years old: As a parent or legal guardian of the above named child, I verify that I fully agree to, understand, and accept all provisions of this Waiver, Release and Consent.

Signature

Printed Name Date

Witness Signature Date

250 University Blvd. Indianapolis, IN 46202-5192
317.274.3432 Phone
317.274.7408 Fax
www.nifs.org

Gleaners Volunteer Release Form

Please Print Clearly!

Today's Date: ________________________________

Are you volunteering with a company, organization or church today? __√___ Yes ______ No

If so, what is the name of your company, organization, school or church? Hollis Adams Foundation ____________________

Volunteer Contact Information

Name (Hereineafter "Volunteer or "the Volunteer"): ____

Street Address: ____ City: ____________________________

State: ________________ Zip Code: ______________ Email: ____

Home Phone: ______________________ Work Phone: ________________ Date of Birth: __________________________

Emergency Contact Name: ______________________________ Emergency Contact Telephone: ______________________

Relationship to Emergency Contact: ____

Minors Names and Date of Birth:

____

RELEASE

Please read this information carefully before signing below!

This release and waiver of liability is in favor of, and shall inure to the benefit of, Gleaners Food Bank of Indiana ("Gleaners") and Gleaners' directors, officers, employees, representatives, agents, successors, assigns, and any and all persons or entities on Gleaners' behalf who may be liable (collectively, "its representatives") and, further shall be binding upon the undersigned and his/her heirs, personal representatives, successors and assigns. The Volunteer desires to engage in any and all activities related to being a Gleaners volunteer, whether on or within the foregoing described premises or elsewhere. Such activities may include, but not be limited to, participating in the assembly line for backsacks, conveyor belt for assembly of senior boxes, working in the Gleaners warehouse or office, and/or doing committee and/or special event work.

Release, Waiver and Assumption of Risk: Acknowledging that such risks exist, and for and in consideration of the permission granted by Gleaners to the Volunteer to engage in the Volunteer's activities, the Volunteer does hereby FULLY and FINALLY RELEASE and DISCHARGE Gleaners and its representatives from, and INDEMNIFY and HOLD HARMLESS Gleaners and its representatives from and against, any and all claims, demands, actions, causes of action, suits, whether at law or equity or otherwise and/or liability of any kind or nature whatsoever, for property damage and/or personal injury, including death, and any and all losses, damages, expense, costs, fees and/or liabilities of whatsoever kind of nature in connection therewith (including, without limitation, attorneys' fees and court costs that may be incurred by Gleaners), arising or resulting from, or in any manner related to, the Volunteer's engaging in the Volunteer's activities. Including, but not limited to, property damage and/or personal injury, including death, caused in whole or in part by the negligence of Gleaners or its representatives or otherwise. The Volunteer recognizes, therefore, that if he/she is hurt and/or his/her property is damaged, while engaged in the Volunteer's activities, the Volunteer will have no right, and hereby waives the right, to make a claim or file a lawsuit against Gleaners or any of its representatives, even if Gleaners or any of its representatives caused the injury or damage. The Volunteer hereby understands the Volunteer's activities include work that may be hazardous to the Volunteer. The Volunteer hereby expressly and specifically assumes the risk of injury or harm to his/her person, including death, and the risk of damage to personal property during the Volunteer's activities and hereby releases Gleaners and its representatives from any duty or obligation owed to the Volunteer. The Volunteer understands and fully recognizes that this Release discharges Gleaners and its representatives from any liability or claim that the Volunteer may have against Gleaners with respect to any bodily or personal injury, including death, or property damage that may result from the Volunteer's activities with Gleaners, whether caused by Gleaners negligence or otherwise. The Volunteer hereby releases and forever discharges Gleaners and any of its representatives from any claim whatsoever which may arise or result from any first-aid treatment or medical service rendered in connection with the Volunteer's activities.

Photographic Release: Volunteer does hereby grant, transfer, and convey to Gleaners all of the Volunteer's right, title and interest in and to all photographic images, video or audio recordings, video or audio reproductions, films or motion pictures, radio or television broadcasts and any other reproductions or depictions (all collectively referred to as the "reproductions") of the Volunteer's activities, or any part thereof, including, without limitation, pictures and sound of the Volunteer alone or with other persons through any and all media, whether now known or hereafter discovered. Such right, title and interest includes, without limitation, the right to any royalties, proceeds or other benefits derived from the reproductions of the Volunteer's activities. The Volunteer hereby understands and acknowledges that Gleaners shall have and own, in connection with the Volunteer's activities, the sole and exclusive right to commercially exploit the Volunteer's activities, and the Volunteer shall not reproduce, sell or otherwise use or exploit any of the reproductions of the Volunteer's activities, or assist another party in doing any of the foregoing, without Gleaners' prior written consent.

Other: Volunteer expressly agrees that this Release is intended to be as broad and inclusive as permitted by Indiana law, and that this Release shall be governed by and interpreted in accordance with Indiana law. Volunteer agrees that in the event that any clause or provision of this Release shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not otherwise affect the remaining provisions of this Release which shall continue to be enforceable.

Volunteer consents to the receipt of future newsletters, mailings and/or notices regarding Gleaners via the postal service or electronic means if an email address is provided. Gleaners will not knowingly sell or distribute the Volunteer's contact information to any other organization or entity.

I have read, understand, and agree to comply with the Volunteer Guidelines. In Witness whereof Volunteer, the undersigned, has executed this Release in Indianapolis, IN on the date written above.

____ ____

Volunteer Signature (Signature of parent or legal guardian if minor) Volunteer Printed Name