CITY OF GRAIN VALLEY RELEASE
& WAIVER OF LIABILITY

Participant/Volunteer: _____ _____
First Name Last Name

Participant/Volunteer Address: _____
Street Name

_____ _____ _____
City State Zip Code

Home Phone: _____ Cell Phone: _____

Email: _____ Date of Birth _____

Parent/Guardian Name:_____ Cell Phone:_____

Work Phone:_____

In consideration of being allowed to participate in the City of Grain Valley Camp Focus activity (hereinafter referred to as "the Activity"), with full understanding that the Activity is dangerous, and notwithstanding the risks of the Activity, on behalf of myself, heirs, dependents, assigns and personal representatives, THE UNERSIGNED

1. HEREBY COVENANTS NOT TO SUE AND RELEASES, WAIVES, DISCHARGES the Releasees ("Releasees" are defined as the City of Grain Valley; officials, and any other employees, personnel or volunteers of the City of Grain Valley, and other Camp presenters) from all liability to THE UNDERSIGNED for any or all loss or damage and any claims or demands therefor on account of injury to the person or property or resulting in death of THE UNDERSIGNED, whether caused by the negligence of the Releasees or otherwise while THE UNDERSIGNED is participating in the Activity;
2. HEREBY ASSUMES FULL RESPONSIBILITY FOR ANY RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE due to the negligence of the Releasees or otherwise while participating in the Activity;
3. HEREBY AGREES TO HOLD HARMLESS AND INDEMNIFY Releasees for any liability sustained by Releasees as a result of any negligent, willful or intentional acts of THE UNDERSIGNED, including any costs, expenses or attorney's fees incurred as a result of such acts.
4. HEREBY AGREE TO BE PHOTOGRAPHED while participating in the Activity; and AGREE TO said Photographs being used on printed Camp Focus program materials or uploaded onto social media platforms.

THE UNDERSIGNED expressly agrees that the foregoing Release and Waiver of Liability is intended to be as broad and inclusive as is permitted by the law of the State of Missouri and that if any portion of this Release and Waiver of Liability is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

THE UNDERSIGNED HAS CAREFULLY READ AND VOLUNTARILY SIGNS THE RELEASE AND WAIVER OF LIABILITY, and further agrees that no oral representations, statements or inducements apart from the foregoing written agreement have been made.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT AND FULLY UNDERSTAND ITS TERMS.

_____ _____
Participant Printed Name Participant Signature

_____ _____
Parent/Guardian Signature Date

City of Grain Valley Camp Focus

PARTICIPANTS WITH SPECIAL HEALTH CARE NEEDS
EMERGENCY PLAN

PARTICIPANT INFORMATION

Participant's Name: _____ Date of Birth: _____

Please provide the information requested below, as it may be needed in case of an emergency.

Conditions requiring special consideration (medical/physical):

Asthmatic **Yes:** _____ **No:** _____ Emergency Phone #

Allergies:

Can participant eat in an area if the offending food is being served?
Can participant sit next to another student who is eating the food?
Can participant eat food that is manufactured in the same area/facility as the offending food?

Does the participant require: (A) **Epipen** Yes ☐ No ☐ (B) **Inhaler** Yes ☐ No ☐ (C) **ANY MEDICATION CURRENTLY TAKEN:** (Type of medication and time of administration):

Please be sure to speak to participant's Doctor/Nurse before July 10, 2026 regarding any medication or special needs the participant may have. THIS INFORMATION WILL REMAIN CONFIDENTIAL. IT WILL STAY WITH CAMP FOCUS COORDINATORS DURING CAMP ACTIVITIES.

Primary contact name | Relationship to student:

Phone #: | Work Phone #: | Cell Phone/Pager #:

Secondary contact name | Relationship to student:

Phone #: | Work Phone #: | Cell Phone/Pager #:

Participant's Physician | Phone #:

TO ANY DOCTOR OR HOSPITAL: I hereby authorize the release of participant's pertinent medical information to the appropriate professional staff. I give permission to the physician or hospital to secure treatment for him/her and to order medications, injections, anesthesia, or surgery for participant, as named above, in case of emergency. The signature below constitutes authorization to perform any necessary treatment for the participant during this field trip.

HEALTH INSURANCE INFORMATION:

Company Name: | Policy #: | Group #:

Parent/Guardian Name: | Date:

(PLEASE PRINT)

Parent/Guardian Signature: