[IN ORDER TO PARTICIPATE IN KALEO, YOU MUST SIGN THIS FORM THE FIRST DAY OF THE PROJECT. PLEASE BE READY TO DO SO.]

Student Mobilization
Medical Release and Liability Waiver

(This form is for participants 18 years or older. Those under 18 must bring a signed Parental Medical Release and Liability Waiver with them to the project. This form is obtainable from StuMo HQs.)

Full Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____-_____-_____ Cell Phone _____-_____-_____ Work Phone _____-_____-_____

Physician's Name _____ Phone _____-_____-_____

Parent Contact Name _____ Phone _____-_____-_____

I hereby waive any claims against, and RELEASE AND HOLD HARMLESS AND INDEMNIFY, Student Mobilization, Inc. and any of their employees, staff, volunteers, agents and representatives from any liability, claim, loss, damage, cost or expense arising from my participation in this project. I waive such claims against such organization or any such person, arising directly or indirectly from or attributable in any legal way, to any action or omission to act of any such organization or person in connection with execution of this event. I authorize treatment by a licensed medical physician or licensed medical team in case of any accident or illness that may so arise, or any hospitalization necessary.

_____
Signature

(The following request is pertinent information if you are rendered unconscious)

Date of Birth (including year): _____ Age: _____

Date of last Tetanus shot: _____

(Contact Student Mobilization immediately if **under 18 years** for a PARENTAL/GUARDIAN CONSENT FORM, LIABILITY WAIVER & MEDICAL CONSENT FORM.)

Please list **ALL** medical conditions /allergies / special health information:

_____

Please list **ANY** medications (prescription or non-prescription) you would like us to be aware of:

_____

Do you have Medical Insurance? ____ Yes ____ No

If yes, please provide the following information:

Insurance Company: _____

Policy in the name of: _____ Policy Number: _____

Name of Emergency Contact: _____ Phone Number _____-_____-_____

In the event the participant does not have insurance, payment in full for medical care becomes the responsibility of the patient.

_____
Signature