

Rose Urban Rural Exchange

Permission for Medical Care and Release of Liability

In consideration of the acceptance and participation of the applicant in the Rose Urban Rural Exchange, the undersigned APPLICANT to the full extent permitted by law, hereby release and agree to save, hold harmless and indemnify, all culture camps, and Native non-profits, Tribal Councils/IRAs and their members, Alaska Humanities Forum board of directors, Rose Urban Rural Exchange task force committee members and employees of the Rose Urban Rural Exchange, the following school districts; Anchorage, Fairbanks North Star and Mat-Su Borough from any or all liability for any loss, property damage, personal injury or death, including any such liability which may arise out of the negligence of any such persons or entities, which may suffered or claimed by such applicant, parent or guardian during, or as a result of, the participation by the applicant in such Rose Urban Rural Exchange, including travel to and from the host culture camp.

I understand that the Rose Urban Rural Exchange does not provide medical insurance, which would cover the participant's injuries or actions. It will be my responsibility as to provide payment for such expenses should they occur, including emergency transportation costs. I am aware of the hazards associated with participation in this activity.

I understand that in the event of an accident or illness and I should become incapacitated, the Rose Urban Rural Exchange and/or the Culture Camp staff will attempt to notify my designated emergency contact.

In the event of an accident or illness where I am incapacitated and my designated emergency contact cannot be reached, I authorize any employee of the Rose Urban Rural Exchange and/or the Culture Camp staff to **select the appropriate medical facility and physician(s)/dentist(s) to provide treatment;**

- I give permission for any operation, administration of anesthetic or blood transfusion which a medical practitioner may deem necessary or advisable for the treatment;
- I further **consent to any medical or surgical treatment by a licensed physician, surgeon or dentist**, which might be required for any emergency situation.

Designated Emergency Contact Name: _____

Business Phone # _____ Home Phone# _____

Cell Phone # _____

Relationship to applicant: _____

Participant's Printed Name

Signature

Dated this _____ day of _____, 20_____