FORMS TO BE RETURNED BOOKLET - ADULT
GROUP EDUCATION PROGRAMS
Medical Record and Participant Acknowledgement and Assumption of Risks and Liability and Indemnity Agreement

North Carolina Outward Bound

IF YOU WILL BE 50 YEARS OF AGE (OR OLDER) AT THE TIME OF COURSE START, YOU MUST HAVE A PHYSICIAN COMPLETE AND SIGN PAGES 5 AND 6 OF THE MEDICAL RECORD.

Welcome to Outward Bound!

All participants are required to complete this booklet. The information you provide informs us of your ability to attend course.

Take time to answer questions completely. Every item in the booklet must be completed. Mark a section "N/A" if it is not applicable to you. Any item or section not completed will require telephone or written follow-up. Failure to fully complete required forms will delay your application. (Keep a copy of this booklet for your records.)

It is imperative that you or your doctor notify our Medical Screener of any significant changes in your health after you submit the booklet and prior to your course start. Our Medical Screener can be reached by calling 800-709-6098 or e-mailing medical@ncobs.org.

North Carolina Outward Bound has a policy of accepting participants who are physically challenged or have special medical conditions providing their condition does not pose a significant safety risk to themselves or others. This long-standing policy is consistent with our educational goals and philosophies as well as our legal and ethical obligations.

MEDICATIONS

If you are taking prescription medication(s), you MUST bring them in ORIGINAL PRESCRIPTION BOTTLES with the physician's dosage directions. If possible, bring a double supply.

Non-prescription or prescription drugs brought on course must be noted in this booklet. Medications listed must accompany the participant on course.

Participants will not be permitted to begin their course without their required medications OR with new medications not approved by our Medical Screener.

INSURANCE

During your course, you should be covered by your own or your family's health and/or accident insurance. Please provide your policy number, company name and address and the policy holder's name, as well as a copy of the front and back of your health insurance card - insert the copies on page 7 of this booklet. Bills for medical treatment will be the responsibility of your insurance company. If you are not covered by health and/or accident insurance, you or your family are responsible for any costs incurred. We suggest you consider purchasing a short-term health insurance plan.

NUTRITION

Outward Bound practices Leave No Trace camping ethics. Therefore, we seldom build fires. You will be cooking on gas camp stoves. Your instructors will teach you how to use the stoves and you will be responsible for helping with the preparation of all meals for yourself and your crewmates. While on course, you will be eating foods that travel well, are light-weight and portable. The food is wholesome, nutritious and selected to meet the high energy demands of the program. We use a lot of hummus, bagels, beans, rice, tortillas, pita bread, peanut butter, jelly, tuna fish, pasta and trail mixes. The amount of physical activity you experience during your course demands a nutritious diet to help fuel your body. Therefore, junk food is not available on course. To prepare, we suggest you cut down on candy, soft drinks, coffee, pastries and other junk foods. Moderating caffeine, alcohol and tobacco consumption will contribute to your fitness. These products will not be part of your Outward Bound course; a clear head and fast reflexes are essential to safety and success on course.

If you are overweight, don't go on a crash diet to shed extra pounds; you will only deplete the strength you want to develop. Please check with our Medical Screener to set a realistic goal for weight loss and stay committed. With advance notice, lactose-free and vegetarian diets can be accommodated. For other diets, such as low fat, vegan and lactose-free vegetarian, it may be necessary for you to bring supplements. Talk with our Medical Screener about appropriate foods and amounts.

REQUIRED SIGNATURES

There are three spaces where you must affix signatures. The applicant must sign page one (1) and page seven (7) of the Medical Record. The applicant must also sign the second page of the Participant Acknowledgement And Assumption Of Risks and Liability Release And Indemnity Agreement. Failure to affix the required signatures will delay the medical review process.

QUESTIONS

If you have questions regarding medical information, contact our Medical Screener at 800-709-6098 or e-mail medical@ncobs.org.

Other non-medical questions should be directed to your Student Services Representative. The Group Education Programs Department can be reached by phone on 800-924-5497 or by e-mail at contracts@ncobs.org.

North Carolina Outward Bound

PARTICIPANT CONFIDENTIAL MEDICAL RECORD

INSTRUCTOR USE

OFFICE USE ONLY

FOLLOW - UP

APPROVAL

PART I - GENERAL INFORMATION

COURSE_____ START DATE_____

Applicant

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other_____

Name_____

Address_____

City/State/Zip_____

Home Telephone_____

Cell_____

Email_____

Gender ☐ Male ☐ Female

Age at Program Start_____ DOB_____/_____/_____

Height_____ ft._____inches

Weight_____lbs.

BLOOD PRESSURE - Taken within 6 months of course start

Blood Pressure_____/_____

Date Taken_____

Blood pressure may be taken with apparatus at a local grocery or drug store.

Parent/Custodial Guardian 1 (if applicant is under the age of 21)

Title: ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Other_____

Name_____ Email_____

Relationship to Applicant_____ Occupation_____

Address_____ City/State/Zip_____

Preferred Telephone #1_____ Preferred Telephone #2_____

Parent/Custodial Guardian 2 (if applicant is under the age of 21)

Title: ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Other_____

Name_____ Email_____

Relationship to Applicant_____ Occupation_____

Address_____ City/State/Zip_____

Preferred Telephone #1_____ Preferred Telephone #2_____

Emergency Contact (not parent/guardian)

Name_____ Relationship_____

Preferred Telephone #1_____ Preferred Telephone #2_____

Ethnic Background (optional)

❑ Asian
❑ Multi-Ethnic
❑ Hispanic or Latino
❑ Caucasian (Non-Hispanic)
❑ Native Hawaiian or Pacific Islander
❑ African American
❑ American Indian/Alaskan Native
❑ Do Not Know Ethnicity
❑ Other_____

SIGNATURE REQUIRED - Consent is hereby given for the applicant to attend an OUTWARD BOUND program and permission is given for any emergency anesthesia, operation, hospitalization or other treatment (whether for an emergency or not) which might become necessary. I agree to be responsible for any and all costs associated with such treatment, including the costs of evacuation, if any. All information will be kept confidential except that information may be disclosed to any medical or other provider as needed for my (or my child's) care. If Outward Bound arranges for treatment for me (or my child) by a medical provider, I authorize that medical provider to release information about me (or my child), and my (or my child's) condition and treatment to Outward Bound. **I understand that I (or my child) may be in remote areas, several hours or days away from any medical facility or where communication, transportation, or evacuation is subject to delay**. If I (or my child) arrive at the program start with a pre-existing medical, behavioral or psychological condition which is not indicated on the medical form and I (or my child) are subsequently unable to participate fully or are forced to leave the program because of that condition, I will forfeit tuition and may be charged an evacuation fee.

Over the years, many students with a variety of medical and psychological difficulties have successfully completed our programs, but we must be aware of these conditions. **Failure to disclose such information could result in serious harm to you (or your child) and fellow students.**

Applicant Signature_____**Date**_____

Parent/Guardian Signature_____**Date**_____

(if the applicant is under the age of 18 or if participant lives in Alabama or Nebraska and is under the age of 19 or if participant lives in Mississippi and is under the age of 21)

PART II - APPLICANT HISTORY: PAST AND PRESENT MEDICAL PROBLEMS

A. If you answer "yes" to any of the items below, please explain. Include the following:

- Specific symptoms that are occurring
- How long the symptom/condition lasts
- Date of last occurrence
- How often the symptom/condition occurs
- How you care for the symptom/condition
- Any restrictions

#	Condition	Y	N	Detailed Description (including restrictions, if any)
1	High Blood Pressure			
2	Heart Disease			
3	Heart Murmur			
4	Irregular Heartbeat/Palpitations			
5	Family history of heart attack			
6	Chest Pain/Pressure			
7	Circulation Problems			
8	Frostbite			
9	Heatstroke			
10	Frequent Dizziness/Fainting			
11	History of altitude sickness			
12	Headaches/Migraines			
13	Head injury with neurological impairment			
14	Tuberculosis/Positive TB test			
15	Asthma or COPD			
16	Active or History of Hepatitis			
17	Lyme Disease			
18	Seizure Disorder/Epilepsy			
19	Seizure within past 6 months			
20	Bleeding/Blood disorder			
21	Sickle Cell Anemia			
22	Sickle Cell Trait			
23	Hypoglycemia (low blood sugar)			
24	Diabetes			
25	Cancer			
26	Thyroid problems			
27	Gastro-intestinal problems			
28	Special Diet			
29	Food Allergies			
30	Kidney Problems			
31	Urinary Tract Problems			
32	Bedwetting			
33	Orthopedic problems			
34	Broken Bones within the past year			
35	Hearing Impairment			
36	Vision Impairment			
37	Skin Problem			
38	Motion Sickness			
39	Sleep Walking			
40	PMS/Menstrual Problems (severe)			
41	Currently pregnant			
42	Medical Equipment/Devices			
43	Other			
44	Other			

B. ALLERGIES (Include allergies to medicine, foods, insect bites/stings, environmental, etc.)

❑ NONE
(Or list to right)

Allergy List Below	Reaction List Below	Medication Required (if any)

C. MEDICATIONS YOU ARE CURRENTLY TAKING

If psychiatric medication, please list any medications taken or changed within the past 3 months.
Also list any over-the-counter, inhalers, herbal supplements, etc.

❑ NONE
(Or list to right)

Medication List Below	Taken For Symptom/Condition	Dosage Size/Frequency	Date Started	Current Side Effects (if any)

NOTE: If you are taking prescription medication(s), you MUST bring them in ORIGINAL PRESCRIPTION BOTTLES with the physician's dosage directions. If possible, bring a double supply. Any changes to the above noted medications or dosages, please contact Outward Bound.

D. HOSPITALIZATIONS/EMERGENCIES/URGENT CARE

Please list any hospital, psychiatric, or urgent care visits within the past year.

❑ NONE
(Or list to right)

Date of Visit/Admittance	Reason	Length of Stay

E. IMMUNIZATIONS

We recommend that all participants have a current tetanus immunization (within 10 years).

F. PERSONAL HISTORY - BASED ON PAST YEAR

1. Have you been diagnosed or treated for any of the following disorders currently or within the past year?

Yes	No		Yes	No	
❑	❑	Attention Deficit Disorder	❑	❑	Developmentally Disabled
❑	❑	Adjustment Disorder	❑	❑	Mood Disorder
❑	❑	Anxiety Disorder	❑	❑	Personality Disorder
❑	❑	Disruptive Behavior Disorder	❑	❑	Pervasive Developmental Disorder
❑	❑	Eating Disorder	❑	❑	Substance Related Disorder
❑	❑	Impulse Control Disorder	❑	❑	Schizophrenia
❑	❑	Learning Disorder	❑	❑	Other _____

2. Have you received treatment or therapy for any of the above, either currently or in the past year?

Yes	No		Yes	No	
❑	❑	Medication(s)	❑	❑	Psychiatric Hospitalization
❑	❑	Outpatient Counseling	❑	❑	Residential Treatment
❑	❑	Day Treatment			

3. Have you experienced any of the following significant events within the past year? If "Yes", please explain.

Yes	No		Yes	No	
❑	❑	Serious Illness_____	❑	❑	Expulsion_____
❑	❑	Serious Accident/Injury_____	❑	❑	Incarceration_____
❑	❑	Self Harm_____	❑	❑	Death of Family/Friend_____

4. Arrange for a release of information with your therapist and/or prescribing physician so we may contact them for further information as part of this screening process. Have you done so? ❑ Yes ❑ No

5. Provide the name, telephone number and email address of your therapist and /or prescribing physician:

Therapist_____ Telephone_____

Fax_____ Email_____

Prescribing Physician_____ Telephone_____

Fax_____ Email_____

G. LIFESTYLE

Do you use alcohol?	❑ Yes ❑ No	How Much?_____	How Often?_____
Do you use tobacco?	❑ Yes ❑ No	How Much?_____	How Often?_____
Do you use recreational drugs?	❑ Yes ❑ No	Which One(s)?_____	How Often?_____
Have you been on probation or had any involvement with the justice system?	❑ Yes ❑ No	Date(s)_____	Reason_____
Do you have a history or current problem with substance abuse or dependency?	❑ Yes ❑ No	How Long?_____	

H. CURRENT EXERCISE ACTIVITY

List the activities you engage in daily or weekly which indicate your current fitness level. Be sure to include all activities.

You will be expected to engage in rigorous physical activity during your Outward Bound experience. It is vital that you start (or continue) a conditioning regimen in preparation for your program.

❑ **NONE**
(Or list to right)

Activity	Frequency	Approximate Time/Distance	Leisurely	Moderately	Intensely

I. SWIMMING ABILITY - (CHECK ONE)

❑ Non-Swimmer ❑ Moderate Swimmer ❑ Current Life Saving Certificate

❑ Weak Swimmer ❑ Strong Swimmer

PART IV - APPLICANT QUESTIONNAIRE

1. What are you looking forward to on your Outward Bound course?

2. What goals are you setting for yourself while on course?

3. How can your instructors and/or crew members contribute to your experience?
   How can you contribute to their experience?

4. Do you have any prior outdoor experience? If "Yes," explain.

5. What concerns, if any, do you have about your Outward Bound course?

BEFORE you sign, please confirm that you have responded to all questions. DOUBLE CHECK page 1 to confirm that you recorded date of birth (DOB), height, weight, and blood pressure. This is REQUIRED information.

Applicant Signature:_____

PART V - INSURANCE INFORMATION

STAPLE OR TAPE A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARD IN THIS SPACE

IF YOU DO NOT CARRY A HEALTH INSURANCE POLICY CHECK HERE: ❒

The following information is needed for our insurance records. Each applicant is responsible for any and all medical expenses and should be covered by his/her own sickness and accident insurance.

Insurance Company Name:_____ Policy Number:_____

Claim Billing Address:_____ City/State/Zip:_____

Prescription Plan Name:_____ Policy Number:_____

Claim Billing Address:_____ City/State/Zip:_____

ADHD MEDICATION QUESTIONNAIRE

COMPLETE THIS FORM IF YOU TAKE MEDICATION(S) FOR ADHD

1. What is the applicant's diagnosis?
   - ❑ Predominantly hyperactive-impulsive
   - ❑ Predominantly inattentive
   - ❑ Combined hyperactive-impulsive and inattentive

2. Name of medication(s)*:_____

   How long has the applicant been taking the medication(s)?_____

3. Does the applicant take this medication:
   - ❑ School Days
   - ❑ Everyday
   - ❑ As Needed
   - ❑ Other_____

4. **Outward Bound is a school and focus is required. We recommend that applicants taking medications for ADHD bring a supply of that medication to use if necessary.**

   Will the medication be brought as recommended above?

   ❑ Yes ❑ No

5. Describe specific symptoms the medication controls:

6. Other comments:

***If you are taking prescription medication(s), you MUST bring them in ORIGINAL PRESCRIPTION BOTTLES with the physician's dosage directions. If possible, bring a double supply.**

Participants will not be permitted to begin their course without their required medications OR with new medications not approved by our Medical Screener.

ASTHMA MEDICATION QUESTIONNAIRE

COMPLETE THIS FORM IF YOU ANSWERED "YES" TO QUESTION #15, PAGE 2

Many applicants with asthma have safely and successfully completed North Carolina Outward Bound courses. Be as detailed as possible.

1. What year was the asthma diagnosed?_____

2. Has hospitalization been required for asthma? ❑ Yes ❑ No
   If "Yes", describe and give dates:

3. Has emergency room treatment been required for asthma? ❑ Yes ❑ No
   If "Yes", describe and give dates:

4. What triggers the asthma? (cold, allergies, exercise, etc.)
   Describe:

5. What medication(s)* are used to control the asthma?

MEDICATION	RESCUE OR DAILY USE	DOSAGE INSTRUCTIONS

***If you are taking prescription medication(s), you MUST bring them in ORIGINAL PRESCRIPTION BOTTLES with the physician's dosage directions. If possible, bring a double supply.**

Participants will not be permitted to begin their course without their required medications OR with new medications not approved by our Medical Screener.

ORTHOPEDIC QUESTIONNAIRE

COMPLETE THIS FORM IF YOU ANSWERED "YES" TO QUESTIONS #33 OR 34, PAGE 2

1. Describe the nature of the applicant's orthopedic condition.

2. Describe the symptom(s) the applicant is experiencing or may experience while on course. What activities trigger these symptoms?

3. What was the date of the first symptom(s)?_____
   What was the date of the most recent symptom(s)?_____
   How long do the symptom(s) last?_____

4. What methods (rest, medication, orthopedic equipment, etc.) are used to alleviate or manage symptom(s)?

5. What impact do the symptom(s) have on the applicant's activity level? Be specific.

6. What is the applicant's range of motion? (full, partial, limited, etc.)

7. Describe the applicant's ability to engage in repetitive motion.

8. What is the applicant's ability to lift and bear weight?

9. Are there any restrictions on activities?

10. Describe the level of activity as it pertains to any orthopedic issues.

11. If the applicant has had surgery, when was it performed?_____

12. What type of surgery was performed?_____

13. Did the applicant undergo physical therapy? ❑ Yes ❑ No

14. Are there plans for future surgery? ❑ Yes ❑ No

FOOD ALLERGY QUESTIONNAIRE

COMPLETE THIS FORM IF YOU ANSWERED "YES" TO QUESTIONS #29, PAGE 2

Name: _____ Course Number: _____

1. List the food(s) that cause problems for the applicant.

Food	Allergy or Intolerance	Date of Last Reaction	Type of Reaction	Treatment Required

2. What is the reaction(s)? Check all that apply.

❑ Wheezing ❑ Nausea ❑ Hives ❑ Anaphylaxis ❑ Vomiting ❑ Eczema ❑ Diarrhea
❑ Itching ❑ Other_____

3. Does the applicant react if:

The food is ingested? ❑ Yes ❑ No
The food is touched? ❑ Yes ❑ No
The food is in close proximity? ❑ Yes ❑ No

4. Is the applicant able to eat foods processed in the same facility as allergen containing foods? ❑ Yes ❑ No
5. Is the applicant able to eat foods processed on the same equipment as allergen containing foods? ❑ Yes ❑ No
6. **If this is lactose intolerance:**
Is the applicant able to consume food containing lactose by taking take Lactaid or similar medication?
❑ Yes ❑ No
7. How was the applicant diagnosed?
❑ Skin Test ❑ Blood Test ❑ Due to Initial Reaction
8. What medication(s) are used to treat the reaction symptoms?

9. Is the applicant willing to bring food supplements? ❑ Yes ❑ No

The food manager may need to contact the applicant directly. Provide contact information.

Preferred Phone 1: _____

Preferred Phone 2:_____

E-Mail Address:_____

Best Day/Time to contact:_____

OUTWARD BOUND
ACKNOWLEDGEMENT AND ASSUMPTION OF RISKS and
LIABILITY RELEASE AND INDEMNITY AGREEMENT

In consideration of the services of North Carolina Outward Bound School, Inc., and its chartering organization, Outward Bound, Inc., and its affiliated Outward Bound Services Group, (collectively referred to as "OB"), participant (and parent or legal guardian of a minor participant) acknowledges and agrees as follows**:**

Acknowledgment and Assumption of Risks

I understand that participant (and parents) share(s) the responsibility for participant's safety, for managing the risks, and for determining the participant's suitability for the program in which he/she will participate. I have accurately completed any required OB application and medical forms and have reviewed all OB program information provided to me. I agree to obey all OB rules, regulations, and policies (and have my child obey them). I have (or my child has) no mental or physical problems or limitations that might affect my (or my child's) ability to participate that have not been disclosed to OB in writing. I have had the opportunity to ask questions about the program activities and the risks of the program in which I (or my child) will participate.

I understand and acknowledge that the program(s) in which I (or my child) will participate has risks and may be physically strenuous. It is impossible to anticipate every activity in which I (or my child) will engage. Outward Bound offers numerous courses with a wide variety of activities. The list below includes many of those activities. The activities in my (or my child's) course will depend on the program in which I am (or my child is) enrolled but may include: hiking, backpacking, skiing, snowboarding, dog sledding, and/or snowshoeing (on and off trail); camping, including cooking over stoves, open fires or by other means; ropes and/or challenge courses (traversing ropes suspended off the ground, potentially at great heights, swinging or traveling by a cable and pulleys and other such activities); rock, wall or tower climbing; physical problem-solving activities; water activities including flat water or white water boating, rafting, canoeing, or kayaking; ocean sailing or sea kayaking; surfing, snorkeling, or swimming; river crossings; bicycling (including mountain biking); mountaineering (snow, glacier or ice travel or travel at high altitude); horseback riding; jogging or stair climbing; vehicle travel and travel by public, chartered or other conveyance; rescue scenarios (real or simulated); community and other service projects that may involve using tools, power equipment, ladders, or construction materials. I understand that I (or my child) may engage in other activities not listed above. The program plan may be modified for any number of reasons, including convenience, weather, emergencies, or unexpected conditions. Activities may take place in the United States or in foreign countries and may be supervised or unsupervised. In particular, participants may have time alone in remote areas. Participants may also be in urban or other areas with exposure to individuals who are not under OB's supervision or control.

It is impossible to know or list every risk associated with every activity. Risks will depend on the program. Some, but not all, of the risks I (or my child) may encounter include: unpredictable or harsh weather; earthquakes; lightning; exposure to extreme temperatures (high heat or extreme cold); exposure to high altitude, avalanches and rock fall; rapidly moving water including whitewater and rough seas; drowning; wild animals and marine life; disease carrying or poisonous plants, insects, animals, and marine life; improper or malfunctioning equipment; slipping, falling or being struck by objects or persons; risks caused or complicated by any mental, physical, or emotional conditions any participant may have; being separated from other participants and leaders for considerable periods; physical contact with other participants or other individuals; and other natural or man-made hazards. Another risk is the potential misjudgment by OB instructors, volunteers, other staff members, co-participants or contractors related to my (or my child's) participation, including but not limited to decisions regarding my (or my child's) physical condition and capabilities, weather, water, terrain, route or medical treatment. All of these risks are inherent to the activities in my OB program, which means that they cannot be changed or eliminated without altering the essential elements of the activity.

I acknowledge that participating in an OB program involves inherent risks and other risks, hazards, and dangers including some not listed above that can cause or lead to death, injury, illness, property damage, mental or emotional trauma, or disability. Furthermore, activities may take place several hours or days from any medical facility or where communication, transportation, or evacuation is subject to delay. I understand that OB cannot ensure my (or my child's) safety and does not seek to eliminate all of these risks, in part, because they facilitate the educational and other objectives of the program. I agree to assume all of the risks of the activities of my (or my child's) OB program, whether inherent or not and whether described above or not.

Liability Release and Indemnity Agreement

I hereby forever release, waive, and discharge OB, and each of its respective agents, employees, officers, directors, trustees, independent contractors, volunteers, and all other persons or entities acting under their direction and control (collectively referred to as "the Released Parties") from, and agree not to pursue a claim or sue the Released Parties or any of them for, any liability, claim, or expense in any way associated with my (or my child's)

enrollment or participation in the OB program or the use of any equipment or facilities. Neither I nor anyone acting on my (or my child's) behalf will make a claim against the Released Parties as a result of any injury, illness, damage, death, or loss. This release includes any losses caused or alleged to be caused, in whole or in part, by the negligence, whether active or passive, of the Released Parties to the fullest extent allowed by law (but not for gross negligence) and includes claims for injury, property damage, wrongful death, breach of contract, or any other type of suit.

I further agree to defend and indemnify the Released Parties (to pay or reimburse the Released Parties for money they are required to pay, including attorney's fees and costs) with respect to any and all claims brought by or on behalf of me, my child, a family member, personal representative, estate, a co-participant, or any other person for any claims related to my (or my child's) enrollment or participation in the program or my (or my child's) use of equipment or facilities, including claims that OB instructors, staff, or volunteers were negligent. This indemnity includes payment for attorney's fees and costs incurred by the Released Parties in defending a claim or suit if the claim or suit is withdrawn or where a court determines that the Released Parties are not liable for the injury or loss.

The National Park Service and certain Forest Services may not allow for the assumption of risks other than the inherent risks or for the release of liability for claims of negligence. Therefore, for activities that occur on lands controlled by these agencies where and to the extent that such a prohibition is in writing for that particular location, program, or permit at the time of the incident and found by a court of proper jurisdiction to be enforceable as a matter of law, the assumption of risk in the above paragraph is limited to assuming the inherent risks; the release of liability is inapplicable; and the indemnity agreement is limited to claims brought by or on behalf of a co-participant or person other than the student or a family member of the student. The assumption of all risks, the entire indemnity provision, and the release of liability shall remain in full force and effect for all activities or any portion of activities which do not transpire on lands controlled by these federal provisions. The indemnity provision for payment of attorney's fees when a suit is withdrawn or where a court determines that the Released Parties are not liable applies to all activities regardless of where they take place.

Additional Provisions

I agree that the substantive law of North Carolina (but not any law that would apply the laws of another jurisdiction) governs this document and any dispute or suit I have (or my child has) with the Released Parties. Any mediation, suit, or other proceeding must be filed or entered into only in North Carolina.

The assumption of risk, release, indemnity agreement, and all other provisions in this document are intended to be interpreted and enforced to the fullest extent allowed by law. Any portion of this document deemed unlawful or unenforceable is severable and shall be stricken without any effect on the enforceability of the remaining provisions, which shall continue in full force and effect. OB has permission to use my (or my child's) photo or image for sale or reproduction in any manner it desires, including advertising or display. OB reserves the right to remove any participant from the program when staff or an instructor believes, in his/her sole discretion, the participant presents a safety concern or medical risk, is disruptive, or acts in any manner detrimental to the program. If I am dismissed or depart (or my child is dismissed or departs) for any reason, I will be responsible for all costs of early departure whether for medical reasons, dismissal, personal emergencies, or otherwise.

I HAVE CAREFULLY READ, UNDERSTAND, AND VOLUNTARILY SIGN THIS DOCUMENT. I UNDERSTAND THAT I AM SURRENDERING CERTAIN LEGAL RIGHTS. I AGREE THAT THIS FORM SHALL BE BINDING ON ME, MY MINOR CHILDREN AND OTHER FAMILY MEMBERS, AND MY HEIRS, EXECUTORS, REPRESENTATIVES, AND ESTATE. I HEREBY WARRANT THAT I HAVE LEGAL AUTHORITY TO ACT ON MY CHILD'S BEHALF. I AGREE, ON MY OWN, AND ON MY CHILD'S BEHALF, TO THE TERMS AND CONDITIONS IN THIS DOCUMENT.

If participant is under the age of 18 (or if participant is a resident of Alabama and is under the age of 19) (or if participant is a resident of Mississippi and is under the age of 21) at the time this document is signed, a parent or legal guardian must sign the release in addition to the participant signing.

_____	_____	_____	_____
Participant signature	Date	Print name here	Date of Birth and Age
_____	_____	_____	
Parent or Legal Guardian signature	Date	Print name here	