## RIGHT TO LIFE OF SOUTHWEST INDIANA

## YOUTH WAIVER AND RELEASE

Youth Participant's Name:_____

Event: March for Life INDY Trip 2026 Date(s): January 22, 2026

I/We, the parent(s)/guardian(s) of the above-named youth, hereby give my/our approval for his/her participation in the above event. I/We assume all risks and hazards incidental to the conduct of the activities and transportation to and from the event I/We do further hereby waive, release, absolve, indemnify, and hold harmless Right to Life of Southwest Indiana and any of their respective affiliates, successors, agents, employees, members, and representatives, adult sponsors, and other volunteers involved in the activities and transportation associated with the event from any and all claims, including claims of personal injury to myself or property damage, under any theory of law (including negligence, but not reckless or intentional conduct) in any way resulting from or arising in connection with the activities and/or transportation to and from the event.

It is understood and agreed that Right to Life of Southwest Indiana, any respective affiliate, successor, agent, employee, member, representative, adult sponsor, nor other volunteer is the insurer of my personal health and safety while I am at functions/events, engaged in supervised activities, or being transported in association with the event. I understand it to be my obligation to provide such insurance as I may desire to purchase to protect myself against the costs of sickness or injury.

In case of emergency or serious illness, should the above-named child require medical treatment, and neither a parent nor the designated family physician can be contacted, consent is hereby granted for such medical treatment as may be considered necessary in the opinion of the attending physician.

I UNDERSTAND THAT MY SIGNATURE RELIEVES RIGHT TO LIFE OF SOUTHWEST INDIANA PERSONNEL OF NAY AND ALL LIABILITY RELATED TO THE ADMINISTRATION OF ANY PRESCRIBED MEDICATION LISTED ON THE MEDICAL INFORMATION FORM (INCLUDING OVER-THE-COUNTER DRUGS).

I represent that I am at least eighteen (18) years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Printed Name:_____

Signature: X_____ Date:_____

# MEDICAL INFORMATION

Name:_____

Address:_____

Primary Contact Name:_____

Primary Contact Phone:_____

Secondary Contact Name:_____

Secondary Contact Phone:_____

Family Physician Name and Phone:_____

Family Insurance Carrier Name and Phone:_____

Insurance Policy Number:_____

List any chronic or existing disease or medical problems (e.g. diabetes, asthma, epilepsy, etc.)

_____

_____

List any medications you are taking on a regular basis:

_____

_____

Should it become necessary, please list any instructions for care of the above:

_____

_____

☐ **Place "X" in box if it is NOT acceptable for your child to be provided over-the-counter medications (e.g. commonly used pain, allergy, or nausea medications).**

X_____ _____

*Parent/Guardian Signature* *Date*