La Montaña
Christian Camps
A Ministry of Latin America Assistance

# Liability Waiver Form

I understand that participation in La Montaña's short term mission experience, with opportunities to work alongside staff at the camp, participate in high adventure activities including, but not limited to ropes courses, archery, biking, trail hiking in the cloud forest, swimming, etc. involve risking bodily harm to the above-stated participant.

In signing below, I assume risk of harm or injury which may occur to the participant as a result of participating in the above-named event or activity. I hereby release La Montaña Christian Camps and their partner, Latin American Assistance, and its officers, employees, or agents from any liability, costs and damages resulting this individual's participation.

I assure La Montaña that there are no health-related reasons or problems which preclude or restrict my participation in the short-term missions experience. I further assure La Montaña that I have adequate health insurance necessary to provide for and pay any medical costs that may directly or indirectly result from my participation in this activity, and I will indemnify and hold La Montaña harmless for any such medical costs.

I also give my consent for La Montaña Christian Camps to seek emergency treatment for the minor if necessary, and I agree to accept financial responsibility for the costs related to this emergency treatment.

*I understand that this Release means I am giving up, among other things, rights to sue the organization, its governing board, employees, and/or agents for injuries (including death), damages, or losses I may incur. I also understand that this Release binds my heirs, executors, administrators, and assigns, as well as myself.*

Signature _____ Date: _____

Name: _____

Address: _____ City _____ ST _____ ZIP _____

# Emergency Medical information

Name: _____ Passport #: _____ Name

of emergency contact: _____ Relationship:

_____ E-mail: _____

Day phone #: _____ Evening phone #: _____

Name of doctor: _____ Phone #: _____

Do you have any **special medical conditions** that we should be aware of during your trip? (Allergies, low or high blood pressure, etc.)

Do you have **any special dietary needs or allergies**?

**List all prescription medication** you are taking:

**Insurance carrier:** (Make sure your policy covers you overseas.)

Company: _____ **Policy #**: _____

Contact phone #: _____

****In the event of a medical emergency,** I hereby authorize those in charge to take me to the nearest licensed physician, medical center, or hospital to secure the necessary treatment to protect my well-being. I will be responsible for all medical costs not covered by my insurance.

Signature _____ Date: _____