

BOROUGH OF KENILWORTH RECREATION DEPARTMENT

CHILD'S NAME – PLEASE PRINT CLEARLY

CONSENT AGREEMENT AND WAIVER OF LIABILITY

In partial consideration of my/our child's acceptance into the

_____ (hereinafter "Program")
Name of Activity

Sponsored or supervised by of the Borough of Kenilworth's Recreation Department (hereinafter "KRD"), I/we do hereby consent to the terms of this Agreement. Whenever KRD is used herein, it shall also include and mean the Borough of Kenilworth, its elected officials, its employees, agents, officers, staff and medical providers.

I/We know the dangers, hazards, and risks of activities, and in consideration of being permitted to have my child participate in the Program, on behalf of myself, my family, heirs, and personal representative(s), I/we agree to forever discharge, hold harmless, release and covenant not to sue the KRD from any and all claims, demands, or causes of action for any injury, death, damage, cost, expense or loss of any kind sustained by my child while participating in the Program. I/We, on behalf of myself, my spouse, family, heirs, and personal representative(s), also hold harmless, release, and agree to indemnify the KRD with regard to any financial obligations or liabilities of any kind that I/we may incur personally or any loss or damage resulting from my child's participation in the Program.

I/We as parents/guardians of _____ do hereby agree to expressly limit the liability of the KRD, to the coverage (if any) of the medical insurance policy covering participants in the designated program.

I/We, understand that any policy of any nature or kind taken by the Borough of Kenilworth may only provide minimal coverage, if any coverage at all, and I/we may not rely on any policy of insurance.

I/We, further agree to waive all liability and hold harmless KRD, for any accident, injury (including death), illness or other mishap which might be-fall my child while traveling to or from, or during his/her attendance at the KRD Program, which may not be covered by said medical insurance policy.

Further, I/we hereby grant permission to any staff and physicians selected by the KRD, and medical or surgical consultant deemed advisable, and any hospital to render to my child any medical and surgical treatment that they deem necessary. I/We understand that all possible effort will be made to inform me/us in case of such treatment, prior to rendering said treatment and that I/we will be responsible for payment if not covered by insurance.

This authorization, release and waiver is intended to be as broad and as inclusive as permitted by the laws of the State of New Jersey. If any portion of the release and waiver is declared invalid, the undersigned agrees that the balance will continue to be applicable.

PARENT AUTHORIZATION TO RELEASE OF INFORMATION

This health history is correct to the best of my knowledge and my son/daughter has my permission to participate in activities with the exception of those noted under physical restrictions. The undersigned further agrees to indemnify, defend and hold harmless KRD from all loss of any kind, liability, damages, costs and expenses (including actual attorney's fees) arising from or related to same. I/We are aware that important rights are being released and given up on the undersigned's heirs, spouse, guardians, executors, administrators or assigns.

I/We represent and assure KRD that after consultation with a medical doctor, there are no health-related reasons that my child should not participate in the activity and recognize that if discipline becomes a problem, my child may be excluded from participation without a refund of any amounts paid. I/We understand that from time to time KRD may publish and even include statements made by my child or photographs my child and the photo may appear in the newspaper or advertisement or over a digital network.

This Agreement constitutes the entire agreement that I/we have carefully read and understand. This Agreement supersedes any prior or contemporaneous agreements, understandings and negotiations, regarding this subject matter.

This Agreement (i) may not be amended, by course of conduct or otherwise, and (ii) may not be assigned in whole or in part, except in writing duly executed by me and approved by formal resolution of the Borough of Kenilworth's governing body. I further agree that this Agreement shall be construed in accordance with the laws of the State of New Jersey, including but not limited to the New Jersey Tort Claims Act, N.J.S.A. 59:1-1 et seq. and New Jersey Contractual

BOROUGH OF KENILWORTH RECREATION DEPARTMENT

Liability Act, N.J.S.A. 59:13-1 et seq. If any term of provision of this Agreement shall be held illegal, unenforceable, or in conflict with any law governing this Agreement, the validity of the remaining portions shall not be affected thereby.

I/We authorize the KRD to release medical information regarding my child to interested parties as KRD reasonably believes required. This Authorization shall lapse two years from the date of execution.

PARENT OR LEGAL GUARDIAN'S NAME (please print clearly)

SIGNATURE

() -

PHONE: Day

() -

PHONE: Cell or Pager

() -

PHONE: Emergency

CHILD'S HEALTH FORM Check all those THAT apply
To be completed and signed by child's parent(s) or legal guardian(s)

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Head Injury/Concussions
<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Convulsive/Seizures	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	HIV

Allergies To Drugs: _____

Allergies To Foods or Insects: _____

Last Tetanus Immunization (date): _____

Current Medications: _____

Chronic or Recurring Illnesses: _____

Operations/Injuries (including dates): _____

Physical Restrictions: _____

BOROUGH OF KENILWORTH RECREATION DEPARTMENT

Physician Name: _____

Physician Telephone: () - _____

Dentist Name: _____

Dentist Telephone: () - _____

Child's Date of Birth: _____

INSURANCE INFORMATION (Must be completed in full to participate)

Insured Name: _____

Insured SSN: _____

Name of Company: _____

Address: _____

Policy Number: () - _____

Phone Number: _____

(please attach a copy of your insurance card and additional medical information, and a doctor's note authorizing use of cast, splint, if applicable, or if recovering from a recent illness or injury.)

Date: _____

PARENT OR LEGAL GUARDIAN'S NAME (please print clearly)

SIGNATURE

PARENT OR LEGAL GUARDIAN'S NAME (please print clearly)

SIGNATURE

Witness Signature

I/We warrant and certify that I/we am/are the parent or legal guardian of the above named child/participant and that I/we have read the Agreement and understand it. I acknowledge each and every part of the agreement (including such parts as may subject me to personal financial responsibility for the participant), and release any claim that I/we may have against KRD, both on my own behalf and in my capacity as legal representative of the participant, including without limitation any claim arising as a result of the participant's leaving the supervision of any claim arising as a result of the participant's leaving the supervision of KRD.

Name of Parent or Guardian (please print clearly): _____

Signature: _____ Date: _____