BLACKHAWK COUNTRY CLUB
MEDICAL AND LIABILITY WAIVER

BOY SCOUTS OF AMERICA
WATER SAFETY COURSE
March 19th 2-4pm

MEDICAL WAIVER

I certify that I am the parent or legal guardian for my child(ren). I hereby give my permission for any Blackhawk employee or agent ("Blackhawk") to seek and give appropriate medical attention for my child(ren) in the event of accident, injury, and illness. I will be responsible for any and all costs associated with any necessary medical attention and/or treatment. I hereby acknowledge that my child(ren) is (are) physically fit and capable of participation in all Boy Scouts of American Water Safety Course activities ("Course"). In case of emergency, I understand that Blackhawk will attempt to reach our family physician, if one is provided to Blackhawk. If our family physician is not available, I give my permission to use the closest medical facility. I also authorize the appointed Blackhawk representative to approve medical or dental treatment for my child in my absence. I hereby waive, release and forever discharge Blackhawk and its associated supervisors, coaches and other agents from all rights and claims for damages, injury, loss to person or property which may be sustained or occur during participation in Course activities, whether or not damages or loss is due to negligence.

BLACKHAWK COUNTRY CLUB LIABILITY AND MEMBERSHIP WAIVER

By registering my child(ren) with the Boy Scouts of America Water Safety Course at Blackhawk Country Club, I consent to their participation in swimming activities and agree that I assume the risk of accident or injuries sustained from whatever cause in connection therewith and release Blackhawk Country Club and it's officers, agents, employees, and it's Board of Directors from any and all liability for any such accident or injury during activities related to Boy Scouts of America Water Safety Course at Blackhawk Country Club. I further authorize the Blackhawk Country Club to seek emergency care for my child/children if I cannot be reached and such treatment is deemed necessary. I assume full responsibility for the costs of such treatments.

Participants Name:_____

Parent or Legal Guardian: _____ Phone: _____

Signature:_____

Family Physician:_____ Phone: _____

Please note any pre-existing medical conditions: _____

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