



Community Bike Collective Rider Consent Form

THIS FORM MUST BE READ, COMPLETED IN FULL, SIGNED AND GIVEN TO THE CBC LEADER BEFORE THE PARTICIPANT MAY GO ON THE OUTING.

EXPRESS ASSUMPTION OF RISK, RELEASE, INDEMNIFICATION AND COVENANT NOT TO SUE AGREEMENT

In consideration for the services of Community Bike Collective, the outing leaders, officers, agents, and volunteers (collectively referred to herein as "CBC"), I, on behalf of myself and/or as the parent or guardian of the minor child participating in the CBC activity, and our heirs agree as follows:

I understand and am aware that mountain biking and related activities including hiking, among other activities, including use of CBC equipment such as backpacks, and bicycles (referred to herein as "Activity"), and transportation to and from such Activity, are HAZARDOUS ACTIVITIES involving INHERENT AND OTHER RISKS of injury to any and all parts of the body. I further understand that injuries in the Activity are a COMMON AND ORDINARY OCCURRENCE, and I have made a voluntary choice for myself and/or the minor child listed below to ACCEPT AND ASSUME ALL RISKS OF INJURY OR DEATH that might be associated with or result from this Activity.

To the fullest extent allowed by law, I agree to RELEASE FROM LIABILITY, and to INDEMNIFY AND HOLD HARMLESS CBC from any and all liability on account of, or in any way resulting from, personal injuries, death or property damage, even if caused by NEGLIGENCE, in any way connected with this Activity. I further AGREE NOT TO MAKE A CLAIM OR SUE FOR INJURIES OR DAMAGES RELATING TO THIS ACTIVITY, even if caused by NEGLIGENCE. I understand and agree that this Agreement is intended to be as broad and inclusive as is permitted by law, and if any portion is held invalid, the balance shall continue in full legal force and effect. I agree that no oral representations, statements or inducements apart from this Agreement have been made.

To accomplish our goals, Community Bike Collective frequently sends press releases and photographs to the media (newspaper, radio, television and the internet), places photos in advertising, and uses photos in our own publications. I grant to Community Bike Collective, their assigns and those acting with its authority and permission, the irrevocable and unrestricted right to copyright, use, and publish any photos taken of me or my minor child during Community Bike Collective activities, including composite and modified representations or in conjunction with my name or my minor's name, for any purpose whatsoever, including illustration, art, promotion, advertising, trade, or any commercial purpose. I waive any right to examine or approve versions of the photos used for publication or materials that may be used in connection with the photos. I further release Community Bike Collective, their assigns, and those acting with its authority and permission, from any liability by virtue of modification or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said photos or in any subsequent processing thereof, as well as any publication thereof, including without limitation any claims for libel or invasion of privacy.

AUTHORIZATION FOR FIRST AID AND MEDICAL TREATMENT

I recognize that medical or dental care may be necessary for myself and/or my minor child. I AUTHORIZE CBC AND THE OUTING LEADER(S) TO RENDER FIRST AID OR EMERGENCY CARE, within the scope of the certification of the outing leader(s). In addition, I authorize CBC to call for medical or dental care for myself and/or my minor child if, in the opinion of CBC, medical or dental care is needed. I AGREE TO PAY FOR ALL EXPENSES AND COSTS ASSOCIATED WITH SUCH CARE AND RELATED TRANSPORTATION. In addition, I hereby authorize and consent for any x-ray examination, anesthetic, medical, dental or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and/or emergency staff and/or dentist currently licensed by the state in which treatment is given and the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health or the equivalent agency in another state. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power to render care which the physician in the exercise of his best judgment may deem advisable. It is understood, medical condition allowing, that effort shall be made to consult the undersigned prior to rendering the treatment to the patient, but that any of the above treatment will not be withheld if the undersigned is incapacitated or cannot be reached.

SIGN AND FILL OUT PAGE TWO OF THIS AGREEMENT

I HEREBY ACKNOWLEDGE THAT ALL THE INFORMATION I HAVE PROVIDED ON THIS AGREEMENT IS TRUE, CORRECT AND COMPLETE. I HEREBY ACKNOWLEDGE THAT I HAVE FULLY READ, UNDERSTOOD AND ACCEPTED EACH OF THE ABOVE PROVISIONS, AND VOLUNTARILY SIGNED THIS AGREEMENT.

NAME OF PARTICIPANT _____ AGE _____

NAME OF PARENT/GUARDIAN _____

SIGNATURE OF ADULT PARTICIPANT OR PARENT/GUARDIAN OF MINOR PARTICIPANT

Date: _____

PARTICIPANT'S EMERGENCY MEDICAL INFORMATION

This information may be used for more than one outing. You must inform the outing leader if any of this information changes from outing to outing.

1. Participant's Name: _____

Parent's/Guardian's Name: (of minor participant)

Address: _____

Phone: _____ Birthdate: _____ Date of most recent tetanus toxoid booster: _____

2. Allergies to drugs, foods, etc. _____

3. Is your child allergic or sensitive to bee stings? _____

Is it ok to give Benadryl if child is stung and showing signs of distress? _____

4. List all medications for which the participant currently holds a prescription and indicate which ones the participant will be taking during outing(s):

5. List all medical conditions of which the outing leader should be aware or which may affect the participant's ability to participate in activities (such as asthma, heart disease, diabetes or neuromuscular or skeletal impairment):

Family Physician: _____ Phone: _____

Insurance Company: _____ Policy Number: _____

List the persons we should call in case of an emergency. We will try to contact them in the order that they are listed below

1. _____ Phone _____
2. _____ Phone _____
3. _____ Phone _____