



**SURVIVAL AIRSOFT GAMING ASSOCIATION (SAGA)
EXPLORER POST 013
2010 RELEASE FORM - BRING TO EACH EVENT**

SECTION 1 - ASSUMPTION OF RISK AND WAIVER

I, the undersigned, understand that the Survival Airsoft Gaming Association (Explorer Post 013) has taken all precautions and reasonable steps to minimize all risks to participants, but is unable to completely guarantee that no injury will come to me. Since the events are mainly conducted outdoors in wilderness areas, there is always the possibility of a slip on rough ground, a fall over obstacles in darkness, or the occurrence of some other unforeseen accident. Further, since I may also be participating in mock battles using airsoft replicas, there is a risk of injury from other participants. While SAGA is committed to safety at our events, it is not possible to control the actions of individuals.

I understand the risks involved in participating in the events sponsored by the Survival Airsoft Gaming Association. I shall make no claim of any description against the organization, its members or its officers, or any land owner or company doing business with the organization for any loss or damages suffered in the course of participating.

I confirm that I am in good physical health and do not suffer from any physical disabilities unknown to the organization. I agree also to the following restrictions placed upon me by the Survival Airsoft Gaming Association.

I will not use the airsoft replicas approved by the organization unless I have first been instructed in their proper use through safety training;

I will not bring or consume alcoholic beverages or illegal drugs during the event; I will not use any skills taught by the organization for illegal purposes;

Unless I submit a written and signed request stating the opposite, I will allow the organization, for promotional purposes, to photograph, film, or videotape me participating in the event; I will at all times abide by the safety rules of the organization.

I understand that failure to abide by these agreements could result in expulsion from the organization or in the extreme, to legal action. By my signature, I confirm that I have read this release, understand its terms, and agree to its provisions. I understand that this form affects my legal rights.

_____ Date _____ Original Signature of Participant (if 18 yr. or older)	< SIGN >	_____ Date _____ Original Signature of Parent(s) or Legal Guardian (if under 18)
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SECTION 2 - MEDICAL INFORMATION AND TREATMENT RELEASE

SAGA activities, like any active sports, involve a certain risk of injury. In the unlikely event that a participant is injured, SAGA would like to take appropriate actions. Please fill out this form completely and legibly. The information on this form is required for admission to any US hospital. This information will be held in strict confidence.

Does the participant have any medical conditions that SAGA / Explorer Post 013 needs to know about to ensure the participant's safety in the event medical treatment is needed? If yes, please list. Include allergies (including bee stings), adverse reactions to any medical drugs, asthma, diabetes, fainting spells, heart trouble, convulsions, bleeding disorders, any others. SAGA requires those who have medical conditions that require special medication (i.e., bee sting allergy) to carry their special medication at all times.

[]No []Yes (explain)

This health history is correct as far as I know, and the person herein has permission to engage in all prescribed activities. In the event I, or the person listed below, cannot be reached in an emergency, I hereby give permission to have 1) Explorer Post 013 members render first aid, and 2) any physician hospitalize, secure proper anesthesia, or order injection for the above listed participant.

_____ Date _____ Original Signature of Participant (if 18 yr. or older)	< SIGN >	_____ Date _____ Original Signature of Parent(s) or Legal Guardian (if under 18)
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Participant (PRINT)		Emergency Contact (PRINT)	
Name		Contact Name	
Address		Address	
City/State/Zip		City/State/Zip	
Phone		Phone	
Birth Date		Relation	
Email Address			

Medical Insurance Information (Plan and Policy Number): _____
 Family Doctor: _____ Phone: _____