

**Eagle's Wings Retreat Center  
2805 Ranch Rd.  
Burnet, TX 78611**

**Parent/Guardian Medical Liability & Photography Release Form**

Dear Parent or Guardian,

We are happy that your son/daughter will be participating in the activities at Eagle's Wings Retreat Center (EWRC). For our records and for any possible emergencies that might arise while at the retreat center, we ask that you fill out and sign this form and this will act as a Medical and Liability Release. Please note that your signature is required in two (2) places. Please be sure all information is correct.

**Participant Information**

Name \_\_\_\_\_ BirthDate \_\_\_\_\_  
Address \_\_\_\_\_ City/St. \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Cell# \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_  
Mother's Address(if different than child) \_\_\_\_\_  
Father's Address(if different than child) \_\_\_\_\_  
Mother's Phone \_\_\_\_\_ Father's Phone \_\_\_\_\_  
(if different than child) (if different than child)

Email address of one parent \_\_\_\_\_

**Parent/Guardian Permission**

I hereby consent to participation by my son/daughter \_\_\_\_\_ in the activities at EWRC. I give permission for my child to be evaluated, diagnosed, treated, and/or given medication in accordance with standard medical practice. I relieve EWRC, its staff, Board members and volunteers of all responsibility and consequence that may arise as a result of this treatment. I will not hold Eagle's Wings Retreat Center, Inc., its personnel, or volunteers liable in the event of injury. Further, I agree to accept financial responsibility as a result of scheduling medical treatment.

I also authorize Eagle's Wings Retreat Center the right use contact information and to photograph and use said photographs in any medium or form of distribution and for any purpose whatsoever, including, without limitation, all promotional and advertising uses.

My child agrees to abide by all rules and regulations stated by EWRC, staff and volunteers. I understand that EWRC will not be liable if my child fails to cooperate with regulations, and that any infraction of the rules may result in immediate dismissal from this facility at my expense.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Participant's Signature \_\_\_\_\_

**Medical and Emergency Information**

Family Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Preferred Hospital \_\_\_\_\_ City \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_  
Allergies \_\_\_\_\_ Current Medications \_\_\_\_\_  
Medical Condition we should be aware of \_\_\_\_\_  
In case of emergency, please contact (If different from above)  
Name \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Opt-out: Please exclude my contact information from any solicitation (if left unchecked we assume you are ok with us contacting you from time to time via email or newsletters)