

Journey Imperfect Faith Community, a Texas non-profit corporation
Women's Retreat 2010

This is an agreement by and between Journey Imperfect Faith Community, a Texas non-profit corporation ("Journey") and _____, hereafter called Participant, regarding rights and responsibilities of Journey and the Participant relative to the Women's Retreat 2010.

IT IS AGREED AS FOLLOWS:

(1) **LIABILITY:** It is agreed that the Participant herein has been apprised of and understands the hazards and liabilities of this activity, and that certain risks and dangers may occur. It is further agreed that the Participant, her representative, heirs and assigns agree to refrain from holding Journey, or its officers, board members, shareholders, employees and agents responsible or liable for any injuries or claims that might occur or arise in connection with Participant's activities in the Women's Retreat 2010. Participant, for herself, her representatives, heirs and assigns, hereby releases and holds harmless Journey and its agents, officers, directors and representatives from any liability actions, causes of action, debts, claims and demands for bodily and/or emotional injury, property damage or loss which may arise in connection with Participant's participation in Women's Retreat 2010. It is understood that all of Participant's activities at Women's Retreat 2010, are entirely voluntary.

(2) **EMERGENCY:** In the case of an emergency, _____, or any other Journey representative conducting the retreat, has permission to make a decision concerning Participant's health if contacts identified below cannot be reached. In case of emergency please contact:

(1) _____ at _____ & _____
() (daytime phone #) (evening phone #)

(2) _____ at _____ & _____
() (daytime phone #) (evening phone #)

(3) _____ at _____ & _____
() (daytime phone #) (evening phone #)

(3) **MEDICAL INFO:** Participant agrees that the following provided medical information is current:

Address: _____ Date of Birth: _____

City/Zip: _____ Phone: _____

SSN: _____

Name & Telephone Number of Physician: _____

Insurance Co. & Telephone Number: _____

Name of Insured: _____

Group Number: _____

Allergies (incl. medications): _____

Current Medications: _____

* If you would prefer to attach a copy of your medical insurance card containing the above information, please feel free to do so. *

•**SIGNED AND
AGREED:**

_____ Date _____
(Signature of Participant)

_____ Date _____
(If under 18, Signature of Parent or Guardian)