Workshop Health & Waiver

Please complete one form for each person attending.

Return to:

GREAT SMOKY MOUNTAINS INSTITUTE AT TREMONT
9275 Tremont Road, Townsend, TN 37882
Fax: 865-448-9250

This form must be completed, signed, and submitted to us prior to the beginning of the program in order to participate. Please print clearly.

PROGRAM____ PROGRAM DATES_________________________

NAME ____ (as you want it on your name tag)

List any health conditions (i.e. special medications, allergies, physical problems) or special circumstances that we ought to know about.

Please share the following information to help us apply for grants. All information will remain confidential.

Male _____ Female _____ Age _____ Race ______________________

Whom should we notify in case of an accident or medical emergency during your stay?

NAME ____

RELATIONSHIP ________________________________ PHONE (______) _______ - ________

I, the undersigned, agree to indemnify and hold harmless GSMIT from all claims, damages, losses, injuries and expenses arising out of, or resulting from, my presence or participation in activities or programs of GSMIT. I further agree not to sue or assert any claim for damages from GSMIT, regardless of whether such claim is for personal injuries or property damage.

I am familiar with the activities in which a participant of GSMIT will engage and I am physically capable of participating in such activities.

In the event of an emergency, I understand that prompt medical treatment may be necessary.* I agree and hereby authorize employees of GSMIT to obtain medical treatment on my behalf. I release GSMIT from liability for such treatment and agree to assume the risk and financial responsibility for such treatment.

The undersigned authorizes the use and production of any and all photographs, slides, film, or videos taken of the undersigned by GSMIT staff, volunteers, or adjunct faculty during the GSMIT program. Such images are the property of GSMIT and may be used in advertising, educational or other promotions on behalf of GSMIT.

____________________________________ ________________

Signature (Parent's signature if minor) Date

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*** This information is required for treatment in the event of a medical emergency.**
It will be cut off and shredded when the program is over.

Date of Birth _____ / _____ / _____ Social Security # ________ - ________ - __________