

**KD ENTERTAINMENT
INDIANA FEAR FARM
JAMESTOWN, IN**

(Please fill out the INSURANCE WAIVER if you DO NOT HAVE INSURANCE OR fill out the INSURANCE VERIFICATION if you DO HAVE INSURANCE)

**INSURANCE WAIVER
(FILL OUT IF YOU DO NOT HAVE INSURANCE)**

We, the parents or legal guardians of _____ Hereby acknowledge
(volunteer name)

that an accident insurance policy is not in force for our son/daughter that will pay the medical or surgical expenses that result from any injury, major or minor, that the above named volunteer may receive as a result of participating in a scheduled event at/for KD Entertainment/Indiana Fear Farm.

Since, we the parents or legal guardians of the above named volunteer so not have an insurance policy which will provide adequate financial coverage for any type of injury or injuries or whatever might result, we, the parents or legal guardians agree to release KD Entertainment/Indiana Fear Farm from any obligation as pertains to financial responsibility in these matters for the event or any period of time thereafter.

Date Signature of Parent or Legal Guardian

**INSURANCE VERIFICATION
(FILL OUT IF YOU DO HAVE INSURANCE)**

We, the parents or legal guardians of _____ have insurance with
_____ policy number _____

That will pay the medical or surgical expenses that result from any injury, major or minor, that the above named volunteer may receive as a result of participating in a scheduled event at/for KD Entertainment/Indiana Fear Farm. This insurance will also cover the above named volunteer while going to or from the scheduled event.

Since we, the parents or legal guardians of the above named volunteer have an insurance policy which will provide adequate financial coverage for any type injury or injuries or whatever might result, we, the parents or legal guardians agree to release KD Entertainment/Indiana Fear Farm or any part thereof, from any obligation as pertains to financial responsibility in these matters for the events this year or any period thereafter.

Date Signature of Parent or Legal Guardian

PERMISSION FOR MEDICAL TREATMENT

In the event of an emergency requiring medical attention, I hereby grant permission to a physician or other hospital personnel designated by KD Entertainment staff to attend to my son/daughter.

Volunteer Name

I expect every effort will be made to reach me before any treatment or hospitalization is undertaken.

Cell Phone: _____ Home Phone: _____ Work Phone: _____

PRINT Parent/Legal Guardian Name: _____ Date: _____

SIGNATURE of Parent/Legal Guardian: _____

CONTACT INFORMATION

(PLEASE PRINT LEGIBLY)

PARTICIPANT'S NAME: _____ Home Phone: _____

IS THE PARTICIPANT A MINOR? YES NO

Address: _____ City: _____ State: _____

YOUR Cell Phone: _____ Date of Birth: _____

MOTHER'S Name: _____ Home Phone: _____

Address: (if different than yours) _____ City: _____ State: _____

MOTHER'S Cell Phone: _____ MOTHER'S Work Phone: _____

FATHER'S Name: _____ Home Phone: _____

Address: (if different than yours) _____ City: _____ State: _____

FATHER'S Cell Phone: _____ FATHER'S Work Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____

CELL PHONE: _____ Home Phone: _____

Work Phone: _____

PLEASE USE THE AREA BELOW TO LIST ANY ADDITIONAL INFORMATION YOU FEEL WE SHOULD KNOW ABOUT YOU OR YOUR CHILD IF FORM IS FOR A MINOR:

