**THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS – READ CAREFULLY BEFORE SIGNING**

**WAIVER OF LIABILITY AND RELEASE OF CLAIMS**

Recognizing there is a risk of injury or death associated with virtually any type of activity, including those activities that will be conducted at the **Hillvue Heights Church,** (“REACH 2021”)to be held at **Hillvue Heights Church, 3219 Nashville Road, Bowling Green, Kentucky 42101,**  on **March 15-16, 2021**, which will include among its events dining, fellowships, worship services (to include singing, speakers, and training), the undersigned, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (also referred to herein as the “Participant”), hereby represent as follows: (*check all that apply*):

( ) I have no physical, mental, emotional or other conditions or illness that would interfere with my ability to participate in any activity or that would endanger my health or safety or the health or safety of others.

( ) I have a physical, mental, emotional or other condition or illness that might endanger my health or safety or the health or safety of others if I were to participate in the following activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

( ) I do not wish to participate in the following activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**COVID-19 ASSUMPTION OF RISK AND WAIVER**

The novel coronavirus COVID-19 has been declared a worldwide pandemic by the World Health Organization. By signing below, I, as Participant, hereby, on my own behalf as well as on behalf of my family members:

* acknowledge the specific and unique risk factors associated with COVID-19 including, without limitation, that it is highly contagious (often spread by person-to-person contact), has a relatively lengthy incubation period, and that certain persons may be asymptomatic carriers and/or spreaders of COVID-19;
* voluntarily and knowingly assume the risk that I may become exposed to, or infected by, COVID-19 at Reach 2021 (and that I may then expose others to, or infect others with, COVID-19 at or after Reach 2021) as a result of my own acts or omissions and/or the acts or omissions of others;
* understand that staff and personnel associated with Reach 2021 will follow the best practices as recommended by federal, state, and local health officials with respect to COVID-19 but acknowledge that those precautions may not be sufficient to prevent the spread of COVID-19 at Reach 2021;
* confirm that I will fully cooperate with all policies and procedures associated with Reach 2021 and pertaining to COVID-19, including, without limitation, related to any symptom(s) that I may exhibit and any positive test result;
* knowingly and willingly elect to participate in Reach 2021, acknowledging that I understand and voluntarily accept any and all associated risks, including, without limitation, for any illness, injury, or death that may result from my attendance at Reach 2021 and participation in its events as well as from any negligent or grossly negligent act or omission by any of the Providers (*as defined below*).

I fully understand and acknowledge that (a) there are risks associated with the aforementioned activity; (b) by consenting to and participating in this activity, I am accepting those risks and I recognize participation in this activity may result in injury, death or disability; (c) **these risks may be caused by the negligence or gross negligence of the Providers (defined below);** and (d) by consenting to and participating in this activity, I hereby assume all risks and all responsibility for any consequences of participation, whether caused in whole or in part by the **negligence, gross negligence, or other conduct** by the Providers.

On my own behalf and on behalf of my family members, I hereby release, covenant not sue, discharge, and hold harmless **KENTUCKY BAPTIST CONVENTION, INC. and HILLVUE HEIGHTS CHURCH BOWLING GREEN (together with each of their respective owners, directors, officers, affiliates, employees, and representatives, the “Providers”)** of and from all claims, actions, liabilities, and damages of any kind arising out of my participation attendance at REACH and participation in its events, and I acknowledge that I specifically understand that by doing so I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the **negligent or grossly negligent acts or other conduct** by the Providers.

**I HAVE READ THE FOREGOING AND I UNDERSTAND THAT IT IS A RELEASE OF ALL CLAIMS.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARTICIPANT NAME (Print) DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARTICIPANT SIGNATURE DATE

MEDICAL INFORMATION

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Illnesses or conditions for which you are currently being treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last tetanus or booster shot: \_\_\_\_\_\_\_\_\_\_

**HEALTH INSURANCE**:

Name of Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT TO TREATMENT

In the event that I am for any reason rendered incapable of making decisions regarding my own medical care, I do hereby consent to treatment, including diagnostic and surgical procedures; by a licensed physician should said physician determine that such treatment is necessary.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARTICIPANT

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE