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## Midwest Adaptive Climbing Trip 2019

Mississippi Palisades State Park, 16327A IL-84, Savanna IL  
*September 6-8, 2019*

### **VOLUNTEER REGISTRATION FORM**

Please complete the attached forms and return to Jason Stubbeman, Synergy Adaptive Athletics Coordinator at [jasons@synergyaa.com](mailto:jasons@synergyaa.com) (*preferred*) or WDSRA, Attn: Synergy, 116 N Schmale Rd, Carol Stream IL 60188.

Every form must be completed in full in order to have a valid registration. Forms must be completed for this trip, regardless of participation in past programs. We will review all forms and confirm with you if you have been accepted for the 2019 trip. Please be sure to check the e-mail you list in these forms for correspondence.

**How will you get to/from Mississippi Palisades State Park? If carpooling, with whom will you travel?**

**What day and time (estimate is OK) do you plan to arrive at Mississippi Palisades S.P.?**

**Do you plan to assist with climbing Friday, September 6<sup>th</sup> in the afternoon (1pm~5pm)?**

**What day and time (estimate is OK) do you plan to leave Mississippi Palisades S.P.?**

**Do you plan to assist with climbing Sunday morning (9am~1pm) or will you depart early?**

Please describe any recent injuries, hospitalizations, or chronic illnesses we should know about and any mental or emotional conditions you experience or have experienced in the past year (i.e. anxiety or panic attacks, substance abuse, etc.).

In order to enhance our ability to help you enjoy the trip safely, please explain in detail any injury or condition you noted above. Please include any medications we should know about.

Please give us a brief description of your current fitness level and related activities.

*Because this is a physically demanding event, we recommend that you check with your doctor before participating if you are unsure if this is a good fit for you. It is your responsibility to ensure you have medical clearance from your doctor to participate in rock climbing and other strenuous activities.*

Do you have any serious allergies that require the use of an EpiPen or other medication?

Do you have any food allergies or restrictions? We will do our best to accommodate you.

Please explain your allergy and/or food restriction.

Have you previously volunteered in an indoor adaptive climbing clinic? What facility/town?

We highly encourage volunteers to bring their own equipment. However, please check needed items:

*Tent  
Sleeping Mat/Pad  
Sleeping Bag  
Head Lamp/Flashlight  
Cot (very limited #'s)*

*Climbing Harness  
Climbing Shoes - If so, what size shoe do you wear?  
Climbing Helmet*

*shoe size\**

***Belay device (volunteers)***

**What is your shirt size (standard mens/adult t-shirt)?**

**What adaptive gear setups/adaptive techniques are you most comfortable with? (i.e. ARC, Side Climbing...)**

**Are you fully belay competent? (i.e. You are able to belay safely and competently with no further training.)**

**Please share your goal(s) for the trip:**

**Please share any concerns you may have about the trip:**

**Is there anything else you would like us to know or discuss prior to the trip?**

# Shirley Ryan AbilityLab Sports and Fitness Program Volunteer Application

**To be completed by volunteer**

First Name:		Last Name:	
Street Address:		City:	
State:	Zip:	Cell Phone:	
Gender:    Male        Female	Date of Birth:	Work Phone:	
Email:		Military Veteran:                      YES    NO	

**Emergency Contact: Please list an emergency contact should there be an incident during an event.**

First Name:	Last Name:
Cell Phone:	Relationship:

**Please indicate if you have:**

Certifications:	Specialized Training:
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**I would like to volunteer for the following sports/activities: (circle all that apply)**

Archery	Boccia	Golf	Handcycling
Wheelchair Basketball	Rock Climbing	Wheelchair Rugby	Sled Hockey
Wheelchair Softball	Junior Sports Programs	Other:	

Days Available							Time of day		
Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Mornings	Afternoons	Nights

**Email Preferences**

The Shirley Ryan AbilityLab likes to keep volunteers informed of important news, schedules, and volunteer opportunities by email however it will not send you any email you prefer not to receive. Please check the kinds of email you would like to receive.

Important Updates & News	Fundraising Events	Recruitment Email	Checklist Reminders	Open Inpatient Shifts <small>Please note that additional credentials are required for inpatient volunteers</small>
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**Agreement**

I certify that the information contained in this application is correct to the best of my knowledge. I understand that the information will be reviewed for completeness and accuracy.

I also agree that if I choose to participate more than three times within the calendar year I will submit to a criminal background check. If I am a minor (under 18 years), I agree to submit a parental consent prior to volunteering.

**Signature of Volunteer:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SHIRLEY RYAN ABILITYLAB ADAPTIVE SPORTS PROGRAM  
PARTICIPATION CONSENT AND WAIVER OF LIABILITY**

I have voluntarily chosen to participate in the Shirley Ryan AbilityLab Adaptive Sports and Fitness Program (the Program). I understand the Program is a year-round, cross-disability sports and recreation program. I understand that as a participant of the Program, I may have the opportunity to observe or participate in many different sporting and social activities and competitions including, but not limited to wheelchair basketball, golf, outdoor programs, powerlifting, wheelchair rugby, sailing, sit volleyball, skiing, sled hockey, kayaking, softball, swimming, tennis, and water skiing.

I understand that transportation to any Program event that takes place at locations other than the Shirley Ryan AbilityLab Adaptive Sports and Fitness Program, 541 North Fairbanks, Mezzanine Level, Chicago, Illinois 60611, may be provided by Shirley Ryan AbilityLab through the use of one of its program vehicles to competitions, practices, or social events. I understand that the vehicle will be driven by Shirley Ryan AbilityLab staff members, Program student interns, or volunteer Program coaches.

I certify that I have consulted a physician regarding my physical condition and that based upon the physician's examination, I am in good physical condition to participate in the Program and to travel to and from any Program events. As with any physical activity or travel, I understand that there are risks of injury associated with my participation in the Program.

By executing this form, I agree that no person or entity, including myself or on my behalf, shall bring any cause of action for damages against Shirley Ryan AbilityLab, including but not limited to its administrators, directors, employees, volunteers or other staff members, as a result of any injury or damages I may suffer or that may arise out of my participation in the Program and/or use of any equipment or supplies provided by Shirley Ryan AbilityLab or used in connection with the Program. I assume all risks of injury due to my participation in the Program except to the extent that such injury may have been caused by the sole proximate cause of Shirley Ryan AbilityLab's negligence.

In the event of an emergency during the course of participation in the Program, the emergency contact listed below will be notified as soon as possible at the phone number listed below.

I understand that, by typing my name below, I am electronically signing this document and that my electronic signature will have the same binding effect as a traditional manual signature. By electronically signing, I confirm that I have read and fully understand this Consent and Waiver of Liability.

Participant's Name (PRINT)	Signature	Date
Emergency Contact Name (PRINT)	Emergency Contact Phone	Relationship

**FOR PARTICIPANTS OF MINORITY AGE**

This is to certify that I, parent/guardian with legal responsibility for this participant, do consent and agree to his/her release as provided above of the Releases, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releases from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE.

I understand that, by typing my name below, I am electronically signing this document and that my electronic signature will have the same binding effect as a traditional manual signature. By electronically signing, I confirm that I have read and fully understand this Consent and Waiver of Liability.

1 <sup>st</sup> Parent/Guardian's Name	Signature	Date
2 <sup>nd</sup> Parent/Guardian's Name	Signature	Date

**Consent to Photograph/Record and Provide  
Health and Treatment Information**

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Patient's First and Last Name ("Patient")

Medical Record # (where applicable)

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Phone Number

E-mail Address

I permit the Shirley Ryan AbilityLab, its contractors, and agents ("SRALab") to take, use, and release photographs, video, other recordings of the Patient ("Images") named above. The Images may be taken, used, and released in the interest of medical science, research, education, donor relations or general public relations for SRALab, or any such other related purposes as SRALab decides is appropriate, without limitation as to the time or date of use. This includes, but is not limited to, making the Images available through broadcast programming, marketing materials and/or website postings, including postings to social media websites such as Facebook or Twitter.

In connection with the use of the Images, SRALab may disclose the Patient's name or other identifying information. SRALab also may disclose information about the Patient's health, such as the Patient's health information, medical condition, and medical or professional treatment, as SRALab deems appropriate, in connection with the use of the Images. The disclosures may be in writing, by e-mail or other electronic method, or in another manner. I can ask to inspect a copy of the Patient health information released under this consent.

Additionally, SRALab respects the privacy of its patients, visitors and staff. Patients, visitors, participants, or SRALab staff cannot be photographed or recorded without their consent.

By signing below, I understand that I am providing formal written consent to SRALab as set out above. This consent lasts for 75 years, but I can take it back ("revoke it") in writing. I can ask SRALab to stop taking Images, or I can revoke this consent, by requesting it within a reasonable amount of time prior to use of the Images. I will send any such request in writing to Privacy Officer, Shirley Ryan AbilityLab, 355 E. Eric Street, Chicago, Illinois 60611 or by e-mail to [privacyofficer@sralab.org](mailto:privacyofficer@sralab.org).

I understand I am not required to sign this consent, and that SRALab will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign it. I understand that health information disclosed under this consent may be re-disclosed by the recipient to others who may not be required to protect it under applicable law. I acknowledge receiving a copy of this form.

I understand that, by typing my name below, I am electronically signing this Consent form and that my electronic signature will have the same binding effect as a traditional manual signature.

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Signature of Patient or Legally Authorized Representative  
(If legally authorized representative, also list relationship to Patient)

Date

# **SYNERGY VOLUNTEER WAIVER & RELEASE**

September 2018 – December 2019



## **IMPORTANT INFORMATION**

The Western DuPage Special Recreation Association (“WDSRA”) and Northeast DuPage Special Recreation Association (“NEDSRA”) are committed to conducting cooperative recreation programs and activities in a safe manner and holds the safety of volunteers in high regard. The Park District/SRA continually strives to reduce such risks and asks that all volunteers follow safety rules and instructions that are designed to protect the volunteer’s safety. However, volunteers must recognize that there is an inherent risk of injury when choosing to volunteer for any activity or program.

Please recognize that WDSRA and NEDSRA carries only limited medical accident coverage for volunteers; therefore, it is strongly urged that all volunteers review their own health insurance policy for coverage. Additionally, each volunteer is solely responsible for determining if he/she is physically fit and/or properly skilled for any volunteer activity. It is always advisable, especially if the volunteer is pregnant, disabled in any way or recently suffered an illness, injury or impairment, to consult a physician before undertaking any physical activity.

## **WARNING OF RISK**

Despite careful and proper preparation, instruction, medical advice, conditioning and equipment, there is still a risk of serious injury when providing volunteer services. Understandably, not all hazards and dangers can be foreseen. Volunteers must understand that depending upon the volunteer services, certain risks, dangers and injuries due to acts of God, inclement weather, slip and falls, inadequate or defective equipment, failure in supervision or instruction, premises defects, horseplay, carelessness, lack of skill or technique, and all other circumstances inherent to the particular volunteer services exist. In this regard, it must be recognized that it is impossible for the SRA to guarantee absolute safety.

## **WAIVER AND RELEASE OF ALL CLAIMS AND ASSUMPTION OF RISK**

Please read this form carefully and be aware that in consideration for providing volunteer services, you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you may sustain as a result of participating in any and all activities connected with and associated with your volunteer services (including transportation services/vehicle operations, when provided).

As a volunteer, I recognize and acknowledge that there are certain risks of physical injury to volunteers in this program/activity, and I voluntarily agree to assume the full risk of any and all injuries, damages or loss, regardless of severity, that I may sustain as a result of my volunteer services. I further agree to waive and relinquish all claims I may have (or accrue to me) as a result of my volunteer services against Western DuPage Special Recreation Association (WDSRA) and Northeast DuPage Special Recreation Association (NEDSRA), and their respective member park districts and communities, adaptive sports program host agencies, officials, agents, volunteers and employees (hereinafter collectively referred as “Parties”).

I do hereby fully release and forever discharge the Parties from any and all claims for injuries, damages, or loss that I may have or which may accrue to me and arising out of, connected with, or in any way associated with my volunteer services.



**I have read and fully understand the above important information, warning of risk, assumption of risk and waiver and release of all claims. If registering on-line or via fax, my on-line or facsimile signature shall substitute for and have the same legal effect as an original form signature.**

### **Waiver Release**

<b>NAME</b>		<b>SIGNATURE</b>	
<b>PARENT/GUARDIAN SIGNATURE</b>		<b>DATE</b>	
<b>VOLUNTEER PHONE</b>		<b>VOLUNTEER E-MAIL</b>	
<b>HOME TOWN</b>		<b>PROGRAM</b>	
<b>EMERGENCY CONTACT NAME</b>		<b>EMERGENCY CONTACT PHONE</b>	
<b>HAVE YOU EVER BEEN CONVICTED AS OR BEEN FOUND TO BE A CHILD SEX OFFENDER?</b>			

## Disabled Sports USA Waiver & Release of Liability Agreement

Disabled Sports USA, and its affiliated Chapters (“Released Parties”) are non-commercial, not for profit activity providers. The purpose of this Disabled Sports USA Waiver & Release of Liability Agreement is to exempt, waive, and relieve Released Parties from any and all liability for any harm, wrongful death, personal injury, property damage, claim or cause of action, including, but not limited to liability arising from the negligence of Released Parties. “Released Parties” include Disabled Sports USA, Adaptive Adventures, and their affiliates, successors, predecessors, parents, subsidiaries, owners, representatives, administrators, directors, officers, agents, coaches, employees, contractors, assigns, and volunteers; other participants, sponsoring agencies, sponsors, and advertisers; and, if applicable, the owners, operators, and lessors of premises on which the activities or events take place.

**In consideration of the undersigned Participant being allowed to participate in any way in Disabled Sports USA and/or Adaptive Adventures related events and activities, the Undersigned (“Undersigned” means the Participant or the Participant’s parent, legal guardian, or legal representative when the Participant is under the age of 18 or legally incapacitated) agrees and acknowledges as follows:**

**1. Risks of Activity.** Participant will be taking part in activities that can be hazardous and involve the risk of physical injury and/or death. The activities are inherently dangerous and Undersigned fully realizes the dangers of participating in the activities. The dangers and risks of the activities include, but are not limited to the condition of the premises and equipment, and the acts, omissions, representations, carelessness, and negligence of the Released Parties. Recognizing the risks and dangers, the Undersigned voluntarily chooses for Participant to participate in the activities and expressly assumes all risks and dangers of the participation in the activity, whether or not described above, known or unknown, inherent, or otherwise.

**2. Release and Indemnification.** Undersigned (a) unconditionally releases, forever discharges, and agrees not to sue the Released Parties for any claims or causes of action for any liability or loss of any nature, including personal injury, death, and property damage, arising out of or relating to Participant’s participation in any Disabled Sports USA/ Adaptive Adventures events or activities or the Participant’s presence on or travel to the premises where such events or activities take place, including, but not limited to claims of negligence, breach of warranty, and/or breach of contract the Undersigned may or will have against the Released Parties; and (b) agrees to indemnify, defend, and hold harmless the Released Parties from and against any liability or damage of any kind and from any suits, claims, or demands, including legal fees and expenses whether or not in litigation, arising out of, or related to, Participant’s participation in such events or activities or the Participant’s presence on or travel to the premises where such events or activities take place.

**3. Helmet Use.** Undersigned agrees that Participant shall use a helmet when participating in the following activities: Alpine skiing, cycling, equestrian, ice hockey, outdoor rock climbing, snowboarding, white water kayaking, white water river rafting, and any other activity when directed by Released Parties. Undersigned understands that a

helmet is in no way a guarantee of safety and that no helmet can protect the wearer against all foreseeable impacts to the head, and that the activities can expose the Participant to forces that exceed the limits of protection provided by a helmet. Undersigned agrees to assume full responsibility for complying with this paragraph and that Released Parties shall not be liable for any injury or damages resulting from Participant’s failure to use a helmet.

**4. Medical Treatment.** Undersigned understands that the Released Parties do not have medical personnel available at the location of the activities. Undersigned hereby grants the Released Parties permission to administer first aid or to authorize emergency medical treatment, if necessary. Undersigned understands and agrees that any such action by the Released Parties shall be subject to the terms of this agreement and release, including any liability arising from the negligence of the Released Parties when administering first aid or authorizing others to do so. Undersigned understands and agrees that the Released Parties do not assume responsibility for any injury or damage which might arise out of or in connection with such authorized emergency medical treatment.

**5. Miscellaneous.** Undersigned agrees (a) Participant will not engage in any activities prohibited by any applicable laws, statutes, regulations, and ordinances; (b) this Agreement shall be governed by the laws of the State of Colorado and the exclusive jurisdiction and venue for any claim shall be located in the state courts located in Jefferson County, CO; (c) this Agreement shall be binding upon the subrogors, distributors, heirs, next of kin, executors, and personal representatives of the Undersigned; (d) this Agreement shall be construed as broadly as permitted by applicable law; and (e) that in the event that any clause or provision of this Agreement shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not otherwise affect the remaining provisions of this Agreement.

**I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND ITS CONTENTS. I AM AWARE THAT I AM RELEASING LEGAL RIGHTS THAT OTHERWISE MAY EXIST. BY SIGNING BELOW, I HEREBY REPRESENT THAT I AM AT LEAST 18 YEARS OF AGE AND FULLY COMPETENT TO SIGN THIS AGREEMENT ON MY OWN BEHALF.**

<b>Participant’s Signature</b>	<b>Participant’s Name (please print clearly)</b>	<b>Date</b>

**FOR PARTICIPANTS UNDER THE AGE OF 18 OR LEGALLY INCAPACITATED**

Undersigned parent, or legal guardian, or legal representative acknowledges that he/she is not only signing this Agreement on his/her behalf, but that he/she is also signing on behalf of the minor or legally incapacitated adult and that the minor or the legally incapacitated adult shall be bound by all the terms of this Agreement. Additionally, by signing this Agreement as the parent, or legal guardian, or legal representative of a minor or legally incapacitated adult, the parent, legal guardian, or legal representative understands that he/she is also waiving rights on behalf of the minor or legally incapacitated adult that the minor or legally incapacitated adult otherwise may have. The Undersigned parent, or legal guardian, or legal representative agrees that, but for the foregoing, the minor or legally incapacitated adult would not be permitted to participate in the activities. By signing below, I hereby represent that I am the parent, legal guardian, or legal representative of a minor, or legally incapacitated adult Participant and that I have the authority to sign on the Participant’s behalf.

<b>Minor’s DOB</b>	<b>Parent/Legal Guardian or Representative Signature</b>	<b>Parent/Legal Guardian or Representative Name</b>	<b>Relationship</b>	<b>Date</b>



## Disabled Sports USA Media Release Agreement

Disabled Sports USA, and its affiliated Chapters (“Released Parties”) are non-commercial, not for profit activity providers. “Released Parties” include Disabled Sports USA, Adaptive Adventures and their affiliates, successors, predecessors, parents, subsidiaries, owners, representatives, administrators, directors, officers, agents, coaches, employees, contractors, assigns, and volunteers; other participants, sponsoring agencies, sponsors, and advertisers; and, if applicable, the owners, operators, and lessors of premises on which the activities or events take place.

### MEDIA RELEASE FORM

**MEDIA/PHOTO WAIVER:** Undersigned authorizes and gives full consent to Released Parties to copyright and/or publish for public view any and all photographs, digital recordings, videotapes, and/or film in which Participant appears. Undersigned agrees that Released Parties may transfer, use, or cause to be used, these digital recordings, photographs, videotapes, or films for any exhibitions, public displays, publications, commercials, art and advertising purposes, television programs, and internet without limitations or reservations.

<b>Participant's Signature</b>	<b>Participant's Name (please print clearly)</b>	<b>Date</b>

### FOR PARTICIPANTS UNDER THE AGE OF 18 OR LEGALLY INCAPACITATED

Undersigned parent, or legal guardian, or legal representative acknowledges that he/she is not only signing this Agreement on his/her behalf, but that he/she is also signing on behalf of the minor or legally incapacitated adult and that the minor or the legally incapacitated adult shall be bound by all the terms of this Agreement. Additionally, by signing this Agreement as the parent, or legal guardian, or legal representative of a minor, or legally incapacitated adult, the parent, legal guardian, or legal representative understands that he/she is also waiving rights on behalf of the minor or legally incapacitated adult that the minor or legally incapacitated adult otherwise may have. By signing below, I hereby represent that I am the parent, legal guardian, or legal representative of a minor, or legally incapacitated adult Participant and that I have the authority to sign on the Participant's behalf.

<b>Minor's DOB</b>	<b>Parent/Legal Guardian or Representative Signature</b>	<b>Parent/Legal Guardian or Representative Name</b>	<b>Relationship</b>	<b>Date</b>