

HOSKING SUPPLY COMPANY FIELD LIABILITY RELEASE WAIVER
(in care of paintball fields and/or rentals)

THIS RELEASE OF LIABILITY MUST BE READ, FILLED OUT COMPLETELY AND SIGNED BEFORE THE PARTICIPANT IS ALLOWED TO TAKE PART IN ANY PAINTBALL EVENT. PLEASE READ BEFORE SIGNING!

Participant's Name: _____ Date of Birth: _____
(please print) (mm/dd/yyyy)

In consideration of being permitted to participate in any way in the sport and activities of paintball under the aspects of the American Paintball League, I acknowledge, appreciate, and agree that:

- I understand the risk of injury from the activity and weaponry involved in paintball is significant, including the potential for permanent disability and death.
- While particular protective equipment and personal discipline will minimize this risk, the risk of serious injury does exist.
- I knowingly and freely assume all such risks, both known and unknown, even if arising from negligence of those persons released from liability below. I assume full responsibility for my participation.
- I understand that the activities of paintball are physically and mentally intense.
- I understand the rules of play and will comply with all rules and regulations.
- If I observe any unusual or unnecessary hazard during my participation, I will bring such to the attention of the nearest official as soon as possible and practical.
- On behalf of all my heirs, assigns, personal representatives, and next of kin release and hold harmless the field owners, employees, officials, volunteers and all persons on the field or in the place of business with respect to all injury, disability, death, or loss or damage to person or property weather caused by the negligence of the released or otherwise.
- I understand and agree that this release of liability agreement covers each and every paintball activity and event in which I participate hereinafter.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT AND FULLY UNDERSTAND THE TERMS STATED HEREIN. I ALSO UNDERSTAND THAT I HAVE GIVEN UP SUBSTANCIAL RIGHTS BY SIGNING THIS DOCUMENT. I SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

X _____ date signed: _____
(participant's signature)

Address: _____ City: _____
State: _____ Zip Code: _____ Phone: (____) _____

FOR PARTICIPANTS OF MINORITY AGE

This is to certify that I, as the parent or guardian with legal responsibility for this participant does consent and agree to the release of any and all liabilities for the participant on the field or in the place of business and any other releases. I concur with the liability release agreement in full as stated above. I furthermore release any liabilities even occurring in property damage, permanent disabilities and even death for myself, my heirs, assigns, and next of kin.

X _____ date signed: _____
(Signature of Parent / Guardian) (mm/dd/yyyy)

Emergency Contacts: #1: _____ Phone: (____) _____
#2: _____ Phone: (____) _____
#3: _____ Phone: (____) _____

COMPANY TERMS OF SERVICE / COPYRIGHT INFORMATION

Consent for Treatment of a Minor

Date: _____
I, _____, being the parent or legal guardian of _____, give my consent for emergency medical and surgical treatment of this minor in the event that such treatment becomes necessary. I grant my permission for treatment in a licensed hospital by a licensed physician and the physician's assistants and designees, including such hospital personnel as the physician may deem necessary. I understand that hospital personnel will make reasonable attempts to contact me before initiating treatment. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. The minor named in this consent form may receive all treatment provided according to generally accepted standards of medical practice with the following

limitations (if none, write "NONE"); _____

My consent is effective for the following time period: From _____ to _____

X _____
(signature of parent or legal guardian)

IF PARENT OR LEGAL GUARDIAN IS OUT OF TOWN, LIST WHERE AND WHEN HE/SHE CAN BE REACHED (list dates, times, locations and phone numbers):

Parent / Legal Guardian

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Father's / Legal Guardian's Workplace

Name: _____

Name of Workplace: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Mother's / Legal Guardian's Workplace

Name: _____

Name of Workplace: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Additional Contact Person

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Preferred Hospital

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Medical Insurance Carrier

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Identification Number: _____

Name of Insured: _____

Family Doctor

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Preferred Surgeon

Name: _____

Phone Number: _____

Medical History

Allergies: _____

Chronic Medical Conditions (diabetes, epilepsy, etc): _____

Medications: _____
