

to pay for all expenses incurred for the transportation of Participant to and Participant's receipt of emergency medical treatment. I understand and agree that USD assumes no responsibility for any injury or damage which might arise out of, or in connection with such authorized emergency medical treatment.

6. Insurance. I represent and agree that Participant is covered by adequate health insurance necessary to cover any and all medical costs that may be incurred as a result of or may arise out of Participant's participation in the Program. I agree to pay for any costs related to the medical treatment of Participant that are not covered by insurance. I have completed and attached the "Medical Insurance Information" form. I also have attached to this signed Agreement a copy of Participant's medical insurance card.

7. Photographs. I consent to the use by USD of any photographs of Participant for publicity, promotion, advertising or other legitimate purposes.

I acknowledge that I have carefully read this Agreement and fully understand its contents. I acknowledge that I am voluntarily executing this Agreement of my own free will after having had the opportunity to consult with legal counsel of my own choosing. I acknowledge and understand that this Agreement releases USD and others described above from any and all liability in connection with any injury or damages or losses of any nature suffered as a result of Participant's participation in the Program. I agree and understand that this Agreement binds all members of Participant's family, estate, heirs, administrators, personal representatives and assigns.

If participant is under age 18, complete the following:

I am Participant's ____parent/ ____guardian, and am fully competent to sign this Agreement. I execute this Agreement for full, adequate, and complete consideration and fully intend for Participant, for me, and for Participant's family, estate, heirs, administrators, personal representatives and assigns to be bound by this Agreement.

Participant's Signature: _____ Date: _____
(If over age 18)

Parent/Guardian Name (please print): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Please return to:
USD Summer Camps & Conferences
Attn: Medical Information
5998 Alcala Park, San Diego, CA 92110
or fax to (619) 260-4185