

**CONSENT & RELEASE FOR EMERGENCY MEDICAL TREATMENT**

I, \_\_\_\_\_, an adult, or the parent/legal guardian of \_\_\_\_\_, a minor, do hereby on my own behalf or on behalf of the minor execute this Consent and Release for Emergency Medical Treatment with *My Secret Vacation*, its parent, subsidiaries, related and affiliated entities, officers, directors, partners, shareholders, employees, agents, successors and assigns. I grant my authorization and consent for the Doctors and his staff to administer emergency medical treatment. I hereby give my consent for any X-ray, anesthetic, blood transfusion, medication or other medical diagnosis, treatment or hospital care deemed advisable by an to be rendered under the general supervision of any licensed physician, surgeon, dentist, hospital or other medical professional or institution duly licensed to practice.

I acknowledge that there is a possibility of complications and unforeseen consequences in any medical treatment, and I knowingly and voluntarily agree to assume any such risk for an on behalf of myself and/or said minor. I acknowledge that no warranty is being made as to the result of any medical treatment.

I hereby agree to release, waive and forever discharge and to indemnify, defend and hold harmless the Released Parties from any and all claims, costs, expenses (including attorney’s fees), liabilities and damages, including but not limited to personal injuries or death, whether foreseen or unforeseen, present or future, known or unknown.

This Consent is intended to be as broad and inclusive as permitted by law, and if any portion thereof is held invalid the balance shall continue in full legal force and effect. IT IS THE INTENTION OF THE UNDERSIGNED, BY SIGNING THIS CONSENT AND RELEASE, TO EXEMPT, RELIEVE, RELEASE, WAIVE AND HOLD HARMLESS THE RELEASED PARTIES FROM ANY AND ALL LIABILITY ARISING OUT OF THE PROVISION OR FAILURE TO PROVIDE MEDICAL CARE, OR ARISING OUT OF THE DISCLOSURE OF MEDICAL INFORMATION OR RECORDS, REGARDLESS OF WHETHER SAME MAY HAVE BEEN CAUSED BY THE NEGLIGENCE OF THE RELEASED PARTIES.

I agree that the health history given as part of my or the minor participant’s registration is correct and to the best of my knowledge. A copy of this Consent may be used in place of the original.

I HAVE READ AND UNDERSTAND THE FOREGOING RELEASE AND ACCEPT AND AGREE TO ITS TERMS AND SIGN IT VOLUNTARILY.

\_\_\_\_\_  
Signature of Patient and Date

Name of Patient	
Address	