Student Name: _____ Student DOB: _____

FORM 1: LIABILITY WAIVER AND INDEMNIFICATION AGREEMENT

The undersigned _____ (the "Participant")
[Student/participant name.]

in consideration for permitting my participation in the following program (the "Program"):

Concord Academy College Tour April 19-21, 2020.
[Describe the Program on this line by listing the name of the school trip]

offered by Concord Academy (the "School") and other valuable consideration, the receipt and sufficiency of which I acknowledge, intending to be legally bound, KNOWINGLY AND VOLUNTARILY EXECUTES THIS LIABILITY WAIVER AND INDEMNIFICATION AGREEMENT on behalf of himself/herself and his/her personal representatives, heirs, and next of kin, represents, covenants, and agrees as follows:

1. Acknowledgment and Assumption of Risk. Participation in the Program is strictly voluntary and involves the risk of serious injury or death. The Participant has voluntarily requested to participate in the Program. Participant agrees to read and abide by the rules and regulations of the Program. Risks from the Program include:

I acknowledge that I have read and understand the Program Description. I understand that participation in the Program, and travel in general, involve inherent risks that are not found in study at Concord Academy. These risks include, without limitations, damage to property, physical illnesses and injuries, including death or other consequences arising or resulting from participation in this activity.

I acknowledge and understand that International travel presents additional risks, which can include, among other things, risks involved in traveling to, from, and within international locations; unfamiliar or different terrain, climate, population density, food and drink, customs, laws, social and sexual mores, safety practices and regulations; difficulty in communication or transportation; criminal and law enforcement activities; acts of war or terrorism; disability access; driving practices; and unavailability of and/or the limited scope and quality of healthcare services. The country or countries to which I will travel may have health and safety standards that differ from those enjoyed in the United States, and I recognize that I may be subject to potential risks, illnesses, injuries, and even death. I have made my own investigation of these risks, understand these risks, and assume them knowingly and willingly.

I understand that, although Concord Academy has organized the Program, it cannot eliminate all risks or guarantee my safety while I am abroad. I have read and understood all information on the U.S. State Department website (https://travel.state.gov/) about the country or countries to which I am traveling, including, without limitations, the U.S. Department of State Consular Information Sheet, information on travel risks, cautions, warnings and recommendations. I have also reviewed the U.S. Centers for Disease Control health advisor information related to travel abroad found at (https://wwwnc.cdc.gov/travel), and any additional information available from International SOS found at https://www.internationalsos.com/private/ConsumerPortal membership number: 11BCAS705120

I understand that I am responsible for obtaining any recommended immunizations before traveling to my destination. With knowledge of this information, I have made the independent judgement to participate in the Program and understand any and all risks involved.

I acknowledge that it is my responsibility to take every precaution to safeguard my health and to protect my personal belongings from damage or theft. I acknowledge that Concord Academy recommends that I never travel alone, particularly at night. Being alone, especially at night, may present additional danger to my safety and well-being.

I acknowledge that I will accept instructions, guidance, and advice from adult chaperones.

Participant understands the risks, both known and unknown, associated with participation in the Program and knowingly and freely assumes all such risks and hazards and all other risks that may arise as a result of participation in the Program or the action, inaction, or negligence of other participants. Because activities in connection with the Program are inherently dangerous and involve the risk of serious injury or death or property damage, the Participant expressly agrees that this Liability Waiver and Indemnification Agreement (this "Waiver") is intended to be as broad and inclusive as is permitted by the laws of the State of Massachusetts.

2. Waiver and Release of Claims. Participant hereby expressly **waives, releases, discharges, and renounces any claims** against the School, its trustees, directors, officers, employees, and agents (collectively, the "Releasees"), for any and all damages, actions, causes of action, liabilities, claims and demands whatsoever, including without limitation, any claims or damages resulting from injury to property or person, including death, which Participant may ever have, arising out of Participant's participation in the Program, including traveling to and from Program activities, and whether or not such loss or injury is caused by the negligence of the Releasees or any of them.

3. Covenant Not to Sue. Participant agrees that it shall never institute or cause to be instituted, any suit, charge, demand, claim, complaint, or cause of action, in law, in equity, or otherwise, in any court, or in any arbitration system or procedure, against the School arising out of Participant's participation in the Program.

4. Indemnification. Participant hereby agrees to indemnify, defend (with counsel reasonably acceptable to the School), and hold harmless the School from and against any and all claims, losses, damages, liabilities, and expenses (including settlement costs and any reasonable legal or other expenses for investigating or defending any actions or threatened actions) the School may incur in connection with any action, claim or dispute arising out of Participant's participation in the Program (including travel to and from Program activities), whether or not such claim is caused by the negligence of the Releasees or any of them.

5. Medical Insurance. The School strongly recommends that the Participant not participate in the Program unless he/she has medical insurance sufficient to cover both minor and serious bodily injuries and that he/she has disability insurance if the Participant is employed or has other significant responsibilities.

6. Consent to Medical Treatment and Release. The School in no way insures, guarantees, or otherwise maintains responsibility for any medical treatment I may require during my participation in the Program. I have provided all requested medical and insurance information and have signed the required Medical Authorization and Release form, as provided.

7. Binding Effect. This Waiver shall bind and inure to the benefit of the Participant and his/her heirs, executors, administrators, legal representatives, successors and assigns.

8. Choice of Law; Jurisdiction and Venue. This Waiver shall be governed by, construed, and enforced in accordance with the laws of the State of Massachusetts (the "State") without regard to the State's conflict of laws principles. Participant submits to personal jurisdiction within the courts of the State. The exclusive venue for resolving disputes arising in connection with this Waiver shall be in state or federal court in the State.

9. No Modification or Revocation of Waiver; One Agreement. Any modification of this Waiver must be in writing and signed by the party to be bound by the modification. The Participant may not terminate or revoke this Waiver. This Waiver constitutes the entire agreement between the parties hereto with respect to the subject matter hereof.

10. Severability. The invalidity of any portion of this Waiver shall not be deemed to affect the validity of any other provision hereof. In the event that any provision of this Waiver is held to be invalid, the remaining

provisions shall be deemed to be in full force and effect as if they had been executed subsequent to the invalid provision being expunged.

11. Enforcement Costs and Attorneys' Fees. In the event that any costs and expenses (including reasonable attorneys' fees) are incurred to enforce any covenant contained in or defend against any claim waived or released in this Waiver, the Participant will pay such costs and expenses.

I HAVE READ THIS WAIVER, FULLY UNDERSTAND ITS TERMS AND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

X_____ _____
(Participant's Signature) Witness

DATE SIGNED: _____ _____
(Participant's Name - Please Print)

PARTICIPANT'S PARENT/GUARDIAN
MUST READ AND SIGN BELOW

This is to certify that I, as parent/guardian with legal responsibility for _____
[Participant's name.]
(the "Participant"), consent and agree to, and agree to be bound by, and perform the obligations of Participant under, this Waiver and Participant's release as provided above of all the Releasees, and each of them, and for myself, my heirs, assigns, and next of kin, I also release and agree to indemnify and hold harmless the Releasees, and any of them, from any and all liabilities incident to my minor child's involvement or participation in the Program, as provided above, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES, OR ANY OF THEM.

PARENT/GUARDIAN:

X_____ DATE SIGNED: _____
(Parent's/Guardian's Signature)

Printed Name:_____ Emergency Phone Number: _____

Student Name: _____ Student DOB: _____

FORM 2: MEDICAL AUTHORIZATION/EMERGENCY CONTACT INFORMATION

Medical Authorization:

I hereby authorize the Program Leader(s) or their designee to act on my behalf, in my absence, and in the event I cannot be reached, to arrange for and give consent to necessary diagnostic procedures, immunizations, and medical and/or minor surgical treatment for my child. I also consent to, and authorize the Program leader, or his/her designee, to arrange for and provide care and treatment (including administering medical and antibiotics) for my child's routine health needs or conditions, such as colds, ordinary infections and minor injuries. I understand and agree that further specific consent will not be obtained at the time the routine care and treatment are provided and that the School will not notify me unless the Program Leaders(s) deem it appropriate or necessary.

In ***rare instances*** a medical or surgical emergency may arise which requires legal consent for treatment by parents or guardians, but the appropriate people may not be located and further delay of treatment may jeopardize life or delay recovery. In such cases, I hereby authorize the Program Leader(s) to obtain on my behalf first aid, emergency medical care, or, if necessary, treatment at an appropriate healthcare facility (including a hospital), for any injuries I may sustain. I also hereby consent to the administration of emergency medical or surgical treatment in the event I am unable subsequent to such injury to give such consent as otherwise necessary. In the event that my child receives treatment in a hospital, I agree to give the hospital permission to send copies of all reports to the Concord Academy Health Center.

Emergency Contact Information:

First Contact:

Name: _____ Relationship: _____

Telephone (home)_____ Telephone Cell_____

E-Mail Address(es): _____

Second Contact:

Name: _____ Relationship: _____

Telephone (home)_____ Telephone Cell_____

E-Mail Address(es): _____

Signatures:

The signatures of the Student and at least one Parent/Legal Guardian are required on this Agreement regardless of the age of the Student. Scanned and facsimile copies of this form will be treated as originals.

_____ _____

Student signature Date

_____ _____

Printed name/signature of parent/guardian Date

_____ _____

Printed name/signature of parent/guardian Date

Student Name: _____ Student DOB: _____

FORM 3: MEDICAL HISTORY FORM - To be completed by PARENT/GUARDIAN

Program Leaders will review this information with the Concord Academy Health Center and will be provided with medical information necessary to ensure the safety of the student during travel.

Medical History - Please indicate below whether your child has been diagnosed with or treated for the following:

Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Hepatitis or other Liver Disease
☐	☐	Heart Disease	☐	☐	Kidney Disease
☐	☐	Emotional Disorders	☐	☐	Eating Disorder
☐	☐	Seizure Disorder	☐	☐	Recurrent Respiratory Issues
☐	☐	Tuberculosis	☐	☐	Head Injury/Concussion
☐	☐	Hypertension	☐	☐	Headaches

Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Chicken Pox
☐	☐	Recurrent sprain/fracture	☐	☐	Lyme Disease
☐	☐	Menstrual Disorder	☐	☐	Mononucleosis
☐	☐	Bleeding Disorder	☐	☐	Learning Disability
☐	☐	Rheumatologic Conditions	☐	☐	ADD/ADHD
☐	☐	Gastrointestinal Disorder			

☐ Other (please list): _____

Please explain any positive answers including dates and important information:

_____

_____

Does your child have any Allergies? For all positive answers please specify allergy and type of reaction.

Yes	No	
☐	☐	Medication/Food Allergies: _____
☐	☐	Bee Sting/Insect Bite/Environmental/Other Allergies: _____
☐	☐	Has your child ever been prescribed an Epi-Pen or Epi auto-injector?

Please list any medical restrictions of limitation to the Student's ability to participate in physical activities:

_____

_____

Are there any other medical or emotional concerns or issues that may impact your child's participation in this Program that we should be aware of? □ No □ Yes
Please explain: _____

Are there any religious beliefs that impact administration of medical care? □ No □ Yes
Please explain: _____

Does your child have any special dietary needs? □ No □ Yes
Please explain: _____

Please list all medication the Student must take during their participation in the Program. Include all over-the-counter/nonprescription AND prescription medications. Be sure to include all inhalers, Epi-Pens, psychotropic medications, and other medications. Be specific about time and dosage.

MEDICATION	DOSAGE
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Family Doctor Name: _____ Telephone/Fax: _____/_____

This health information is accurate and complete insofar as we know. The Student has permission to engage in all activities except as noted above. Scanned and facsimile copies of this form will be treated as originals.

_____ _____

Signature of Parent/Guardian Date

Concord Academy Health Center

FORM 4: Permission Form for Off-Campus Travel Over the Counter Medication Administration by Nonclinical Chaperone

Student:_____DOB:____/___/_____
Last Name First Name Month Day Year

Trip Name: ***Concord Academy College Tour April 19-21, 2020***

The following medications will be available in the chaperone's first aid kit. Please note that the chaperone is not licensed to make medical diagnoses or treatment recommendations. If you give your student permission to ask for the listed medications, your signature indicates that you understand that the chaperone is not administering medical advice and you have reviewed each medication with your child, approve of the suggested dose and frequency, and have verified that your child does not have an intolerance or allergy to the medication.

For each medication listed below, please mark "YES" or "NO" to indicate whether or not you and your physician give the Concord Academy off-campus travel chaperone permission to administer the medication to the student. These medications are stocked in the chaperone's first aid kit.

Name of Medication	Formulation and Route	Dose and Frequency	Indications	Permission	
acetaminophen (Tylenol)	325 mg tablet taken by mouth and swallowed	2 tablets by mouth every 4 hours as needed, (maximum 9 tabs per 24 hours)	To relieve headaches, minor aches, fever, menstrual cramps. Contains no aspirin.	YES ☐	NO ☐
antacid (Mylanta/Maalox/Tums – calcium carbonate)	420 mg chewable tablet	1 tablet by mouth three times per day as needed	Provides temporary relief of stomach upset, acid indigestion and/or nausea.	YES ☐	NO ☐
anti-itch gel (camphor/zinc acetate/diphenhydramine)	Topical gel applied to skin	Apply to affected area three times per day as needed. Do not use for more than 7 days.	Relieves itching of skin irritations due to insect bites, minor cuts or scrapes. Dries the oozing and weeping of poison ivy, oak and poison sumac. Do not use in or near eyes or with any other product containing diphenhydramine.	YES ☐	NO ☐
bacitracin	Topical ointment applied to skin	Apply to affected area three times per day as needed. Do not use for more than 7 days.	To help prevent infection in minor cuts and scrapes. Do not use in or near eyes.	YES ☐	NO ☐
bismuth subsalicylate (Kaopectate, Pepto Bismol)	262 mg chewable tablet	1 tablet by mouth every hour as needed, not to exceed 8 doses in 24 hours	Relieves symptoms of an upset stomach, such as heartburn, indigestion, nausea, and diarrhea.	YES ☐	NO ☐
cold relief multi-symptom (acetaminophen/guaifenesin/ phenylephrine/dextromethorphan)	Each tablet contains: Acetaminophen 325mg, guaifenesin 200mg, phenylephrine 5mg,dextromethorphan 15mg. Taken by mouth and swallowed	1 tablet every 4 hours as needed, not to exceed 4 doses in 24 hours	Relieves congestion, pain, cough, and fever. Contains no pseudoephedrine.	YES ☐	NO ☐

cough drop/throat lozenge (Halls cherry)	Menthol 7.6 mg dissolvable tablet	1 tablet by mouth (dissolve slowly in mouth) every hour as needed. Maximum 8 per 24 hours.	Temporarily relieves cough, minor throat pain or irritation.	YES ☐	NO ☐
diphenhydramine (Benadryl)	25 mg capsule taken by mouth and swallowed	1 capsule by mouth every 6 hours as needed	For mild to moderate allergic reaction. Contains antihistamine for temporary relief of sneezing, runny nose, itchy eyes and throat due to allergy and colds and/or pain & swelling due to insect bites.	YES ☐	NO ☐
hydrocortisone 1%	Topical cream applied to skin	Apply to affected area twice daily as needed. Do not use for more than 7 days.	Topical steroid used to treat inflammation of the skin due to conditions such as allergic reactions, eczema, or psoriasis. Do not use in or near eyes.	YES ☐	NO ☐
ibuprofen (Motrin/Advil)	200 mg tablet taken by mouth and swallowed	2 tablets taken by mouth every 6 hours (with food)	To relieve headaches, tooth aches, minor aches, fever, menstrual cramps. Contains no aspirin. *Caution: people with a severe allergic reaction to aspirin must not take ibuprofen.	YES ☐	NO ☐
loratadine (Claritin)	10 mg tablet taken by mouth and swallowed	1 tablet by mouth every 24 hours as needed	Non-sedating antihistamine for nasal congestion, sneezing, watery eyes, runny nose due to colds or allergies.	YES ☐	NO ☐
meclizine (Dramamine, Antivert)	25 mg tablet taken by mouth and swallowed	1 tablet taken by mouth every 24 hours as needed	For nausea, vomiting, dizziness associated with motion sickness.	YES ☐	NO ☐
phenylephrine (Sudafed PE)	5 mg tablet taken by mouth and swallowed	2 tablets every 4 hours as needed, not to exceed 4 doses in 24 hours	Treats nasal and sinus congestion.	YES ☐	NO ☐

By signing below, I, the student's parent/guardian, give permission for Concord Academy nonclinical medical chaperones to assist my child in self-administering the above over-the-counter medications for the symptoms and doses indicated above if needed. Please remember that the chaperone is not licensed to make medical diagnoses or treatment recommendations. If you give your student permission to ask for the listed medications, your signature indicates that you understand that the chaperone is not administering medical advice and you have reviewed each medication with your child, approve of the suggested dose and frequency, and have verified that your child does not have an intolerance or allergy to the medication.

Parent/Guardian Name: _____

Please Print

Student Name: _____

Please Print

Date: _____

Parent/Guardian Signature: _____