RESTON COMMUNITY CENTER
EMERGENCY CONTACT FORM

Your Name: ______________________________

Address: ______________________________

Street/Apt #

____

Town/City State Zip

Home Phone: ______________ Cell: ______________

FIRST EMERGENCY CONTACT

Name: ______________ Relationship ______________

Home Address: ______________________________

Street/Apt #

____

Town/City State Zip

Home Phone: ______________ Business Phone: ______________

Cell: ______________ Email: ______________

RELEASE

AUTHORIZATION: I give permission to the physician selected by the Reston Community Center to secure the administration of necessary medical treatment in case of an emergency. I also understand that any medical expenses incurred will be billed directly to my insurance company. In case of emergency, the Reston Community Center will use the closest available emergency facility.

Signature: ______________________________ **Date:** ______________

By my signature below, I hold the Reston Community Center, the Governing Board of the Center, the Fairfax County Board of Supervisors, the Employees of the Center and the volunteers, harmless from any and all liability for damages or harm arising from my participation in this program. I acknowledge that under Virginia law, the County, its agencies and, to a lesser extent, its employees, are immune from liability arising from legal suits based on tortious injury. Finally, I have been advised to carry my own insurance.

Signature: ______________________________ **Date:** ______________