A WAY OUT PROGRAM WAIVER

☐ This is to certify that I, _____, am over the age of 18 **AND I DO NOT HAVE ANY PENDING CRIMINAL CHARGES AGAINST ME.**

☐ This is to certify that _____ is under the age of 18 and participant's parent/legal guardian _____ hereby authorizes the minor's participation in the A Way Out program and, further, said parent/legal guardian agrees to be bound by this waiver both individually and on behalf of the minor.

☐ I further agree and understand that I am voluntarily turning over any drugs (legal and illegal) as well as any drug paraphernalia in my possession to the participating police agency, which shall immediately be destroyed. And that in exchange for working towards my sobriety through the A Way Out program, the participating police agency and/or the Lake County State's Attorney's office will not file criminal charges against me for use and/or possession of these items.

☐ I agree and understand that I remain responsible for any and all charges and expenses related to the treatment I may receive as a result of this program.

☐ I agree that an officer from the participating police agency may contact the Lake County Health Department on my behalf to start the intake program for the A Way Out program.

☐ I agree to allow a volunteer screener to accompany me during my intake to a hospital and to discuss my care and treatment at the facility with hospital staff and physicians.

☐ I agree that if there is any exchange of contact information (phone numbers, email addresses, physical addresses, etc.) with the screener, this will be done only with mutual agreement between myself and the screener.

☐ I further understand that at any time I no longer feel comfortable with the volunteer screener I can request a new volunteer screener (if available) or to not have a volunteer screener assigned to me.

☐ I also agree to be contacted in the future by the participating Police Department and Lake County Health Department to tell them about my experience in the program. I understand that the information I provide may be used by these agencies to help improve the program.

☐ I also agree to allow any and all treatment centers that I attend as part of this program to update the _____ Police Department and/or the Lake County Health Department on the status of my treatment and/or any other issues deemed relevant. This is done purely for statistical reasons and will be used for follow up on the program. These updates will be secure and strictly confidential.

☐ **I understand that I am assuming all risk for any and all claims arising from my participation in the A WAY OUT program and that on behalf of myself and my heirs, I do hereby RELEASE the Lake County Health Department, the Lake County State's Attorney's Office, the participating police agency as well as the volunteer screener, and their assigns, successors, employees,**

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volunteers, participants, and any other person(s) or entity involved in the operation, organization, sponsorship, supervision, training or participation in the A WAY OUT program from any and all liability, losses, claims, demands, suits, damages and/or causes of action for personal injuries and/or property damage I may have, suffer or sustain while I am participating in the A WAY OUT program, whether arising from my own acts, actions, activities, and /or omission or those of others.

☐ I agree that Illinois Law will govern any and all legal disputes arising from this Release and further agree that any and all litigation arising from said dispute(s) will be filed and litigated in the 19th Judicial Circuit of Lake County, Illinois.

☐ I have read the foregoing and I agree to be bound by the terms and conditions of the Release.

Printed Name _____ Signature _____

Printed Name of Guardian if under 18 _____ Signature _____

Address _____

Date of Birth _____

Date _____

Please Fax this Form to Lake County Crisis Care Program [redacted]

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