Print Form

Assumption of Risk and Release and Medical Consent

Name of Child (PRINT Last Name, First Name, Middle Initial): _____

I certify that the above named child is in good physical health and able to participate in _____ (camp) presented by the University of Hawai`i, which is scheduled for _____. I understand and acknowledge the dangers and risks involved in my child's participation in the camp which include, but are not limited to, minor injuries such as bruises, lacerations, strains, and sprains, over exertion injuries (such as heat stroke, cardiac arrest or respiratory arrest), broken bones or dislocations or the possibility of permanent disability and death, as well as property loss and severe social and economic loss. The dangers and risks may be caused by, but are not limited to: (a) the actions, omissions or negligence of the instructors, sponsors, participants, volunteers, spectators; (b) conditions of the premises and/or equipment used; (c) temperature and/or weather; (d) conditions of other participants. I understand that as a parent/guardian of the above named child, I am encouraged to obtain a physician's clearance for my child prior to participation in the above named activity.

I understand that my child should have his/her own private medical and liability insurance coverage if they intend to participate in the camp, and that the University of Hawai`i does not provide insurance for my child and will not be financially responsible for my child or indemnify my child with respect to injuries or liabilities arising out of my child's participation in the camp.

The camp will attract media coverage. My child may be photographed and/or video taped while participating in the camp, and the photograph and/or video tape may appear in print media and/or live or replay telecast. I therefore grant my permission for my child to be photographed and/or appear in a telecast of the camp if my child participates in the camp.

In consideration of my child being permitted to participate in the camp, I agree to assume all risks of injury and loss resulting from my child's participation in the camp. I read and understand all written materials setting forth the requirements for my child's participation, and understood all oral instructions, and my child will strictly observe them during his/her participation. Most importantly, for myself, my heirs, executors, and administrators, I accept full responsibility for my child's participation in the camp and **I agree to defend, indemnify, release and discharge the State of Hawai`i, the University of Hawaii, its Board of Regents, officers, employees, agents and assigns from any and all liability, claims, demands or actions for property damage, personal injury and/or death arising or resulting from or caused by any acts or omissions by my child or others during their participation in the camp**.

I also agree that this Agreement shall be construed in accordance with the laws of the State of Hawai'i. I further agree that if any portion is held invalid, the remainder will continue in full legal force and effect.

I have read this Assumption of Risk, Release and Indemnity Agreement and I understand that I am giving up substantial rights, including the right to sue. I acknowledge that I am signing this Agreement freely and voluntarily.

MEDICAL CONSENT

I, the undersigned, consent to, and authorize any medical professional and others working under their supervision to treat my child for any injury or illness arising from or related to my child's participation in the camp, and agree to pay any and all medical expenses, costs and other charges, and to defend, indemnify, release and discharge the State of Hawai`i, , the University of Hawaii, its Board of Regents, officers, employees, agents and assigns from any and all liability, claims, demands or actions arising from or connected with such medical treatment or care.

_____ _____
Signature of Parent(s)/Guardian(s) Date

_____
Print Name

EMERGENCY CONTACTS:

First Person to Contact: _____ Phone: _____

Second Person to Contact: _____ Phone: _____

Physician to Contact: _____ Phone: _____

Medical Insurance Information (if applicable): Carrier Name (i.e. HMSA, Kaiser, etc..): _____

Subscriber Name: _____ Subscriber ID Number: _____

Preferred Hospital Facility: _____