UNIVERSITY OF HAWAI’I

Name (Last Name, First Name, Middle Initial): ____________________________________________
Department/Program: __________________________ Dates of Event: _________________________

ASSUMPTION OF RISK AND RELEASE

I/We, the undersigned, certify that the above named child is in good physical health and is able to participate in all activities of the above named program.

I/We also understand that because of the inherent dangers and risks involved with participation in the above named program at the University of Hawai’i, which is scheduled for the above named period, that I/We should be covered during said period by a private medical and liability policy; and I/We further understand that the University of Hawai’i does not provide such insurance or otherwise indemnify individuals with respect to injuries or other liabilities arising out of participation in the above named program.

Therefore, in consideration of the above named child being permitted to participate in the above named program, I/We hereby agree to assume all risks and responsibilities surrounding his/her participation in the above named program. I/We have read and understand any and all written materials setting forth the requirements for participation in the above referenced activity, as well as those explained by the instructor(s), and I/We agree to strictly observe them. Further, I/We do for myself, my heirs, executors, and administrators hereby accept full responsibility for my child’s participation and agree to indemnify, release and discharge the University of Hawai’i, State of Hawai’i, its officers, employees, agents, and assigns from any and all claims or actions for property damage, personal injury, and/or death arising from such participation in the above named program or growing out of or caused by any acts or omissions of the above named child during their participation in above named program.

Signature of Parents/Guardian(s) __________________________ Date __________________________

Print Name(s)

MEDICAL CONSENT FORM

I/We, the undersigned, consent to and authorize any medical professional and others working under their supervision to treat the above named child for any injury or illness arising from or related to my participation in the above named program.

I/We further agree to pay any and all medical expenses, costs and other charges and to release and discharge and hold harmless the University of Hawai’i, State of Hawai’i, its officers, employees, agents, and assigns from and against any liability or any claims or demands arising from or connected with such medical treatment or care.

IN CASE OF EMERGENCY:

First Person to Contact: __________________________ Phone: __________________________
Second Person to Contact: __________________________ Phone: __________________________
Physician to Contact: __________________________ Phone: __________________________

Signature of Parents/Guardian(s) __________________________ Date __________________________

Print Name(s)