

Agreement for Assumption of Risk, Indemnification, Release, and Consent for Emergency Treatment

I, _____ (print name), age _____, desire to participate voluntarily in _____ at the University of Wisconsin – Superior

I UNDERSTAND THAT I AM BEING ASKED TO READ EACH OF THE FOLLOWING PARAGRAPHS CAREFULLY. I UNDERSTAND THAT IF I WISH TO DISCUSS ANY OF THE TERMS CONTAINED IN THIS AGREEMENT, I MAY CONTACT:

Steve Nelson, OF THE UW- Superior, AT TELEPHONE NUMBER: 715-395-4619

Assumption of Risks:

I understand that not all risks can be foreseen and there are some risks which are unpredictable. I understand that certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. I am aware of the risks of participation, which include, but are not limited to, the possibility of physical injury, fatigue, bruises, contusions, broken bones, concussion, paralysis, and even death. I understand that the university has advised me to seek the advice of my physician before participating in _____. I understand that I have been advised to have health and accident insurance in effect and that no such coverage is provided for my by the University or the State of Wisconsin. **I know, understand, and appreciate the risks that are inherent in the above-listed programs and activities. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.**

Signature: _____ Date: _____

Signature of Parent or Guardian
(If Participant is under 18*): _____ Date: _____

Hold Harmless, Indemnity and Release:

In consideration of my participation in these activities, I, for myself, spouse, heirs, personal representatives, estate or assigns, agree to defend, hold harmless, indemnify and release the Board of Regents of the University of Wisconsin System, the University of Wisconsin-Superior, and their officers, employees, agents, volunteers, and all others who are involved, from and against any and all claims, demands, actions, or causes of action of any sort on account of damage to personal property, or personal injury, or death which may result from my participation in the above-listed program. This release includes claims based on the negligence of the Board of Regents of the University of Wisconsin System, the University of Wisconsin- Superior, and their officers, employees, agents, and volunteers, but expressly does not include claims based on their intentional misconduct or gross negligence. **I understand that by agreeing to this clause I am releasing claims and giving up substantial rights, including my right to sue.**

Signature: _____ Date: _____

Signature of Parent or Guardian
(If Participant is under 18*): _____ Date: _____

Consent for Emergency Treatment:

I authorize the University of Wisconsin- Superior and its designated representatives to consent, on my behalf, to any emergency medical/hospital care or treatment to be rendered upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

Signature: _____ Date: _____

Signature of Parent or Guardian
(If Participant is under 18*): _____ Date: _____

*If your son, daughter or ward will be under 18 while participating in _____ at the University of Wisconsin – Superior, it is our policy to request your agreement to the above terms, on behalf of your minor son, daughter or ward.

University of Wisconsin Superior

**PART ONE:
CONSENT FOR MEDICATION ADMINISTRATION
and MEDICAL TREATMENT**

TO THE PARENT(S) OR LEGAL GUARDIAN:

If your son, daughter, or ward will be under the age of 18 while at the University of Wisconsin-Superior, it is camp policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device can be self-administered or be administered by the Camp Health Supervisor.

All medications must be in a medicine bottle and labeled with the camper's name, doctor's name and phone number, medication name, and dosage. You must also complete the form below:

_____ No medication has been brought to camp.

_____ I want the medication or medical devices self-administered. (Age 14 and above only.)

_____ I want the medication or medical device administered by the Camp Health Supervisor. However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

.....		
_____	_____	_____
Name of Medication (s)	Prescribing Doctor	Doctor's Phone #
.....		
_____	_____	_____
Amount to be taken	How is it taken?	When to be administered
.....		
_____	_____	
Day(s) to be taken	Special Instructions	

- If your son, daughter, or ward will be under the age of 18 years while at our camp, it is our policy to secure your consent for medical treatment.
- By signing below you are giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- By signing below you are stating that you are aware of and accept the risk inherent in the program activity.
- By signing below you agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin-_____, their officers, employees and agents, from any and all liability, loss, damages, or expenses which are sustained, or required arising out of the actions of your dependent in the course of the camp/event.

Participant Name (Please Print)

Signature of Parent or Guardian

Date

PART TWO: HEALTH HISTORY QUESTIONNAIRE

Full Participant Name:		XXXXXXXXXXXX	Name of Camp/Event		Camp Dates
Full Home Address:		Home Telephone Number:		Date of Birth: ____/____/____	Sex: M F
Parent/Guardian Name:		Relationship:		Height:	Weight:
Address (if different than above)		Home Telephone Number:(if different than above)		Does participant have allergic reactions to:	
		Parent/Guardian Work Telephone:		<input type="checkbox"/> Yes <input type="checkbox"/> NoPenicillin <input type="checkbox"/> Yes <input type="checkbox"/> NoOther Antibiotics _____ <input type="checkbox"/> Yes <input type="checkbox"/> NoOther Medicine (type) _____ <input type="checkbox"/> Yes <input type="checkbox"/> NoInsect Bites/Stings _____	
Alternate contact in the event that the Parent/Guardian cannot be contacted during an injury or illness. (Name, Relationship, Address, and Telephone Number)				Does participant take medication on a regular basis?	
				<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Identify _____ (consent for medication administration must be signed on reverse.)	
Physician: _____ Telephone: _____				Has participant had or presently experiencing:	
Insurance Co.: _____ Policy No.: _____				<input type="checkbox"/> Yes <input type="checkbox"/> No Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures/Blackouts <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Injury/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Menstrual Difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No Mental/Emotional Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Neck/Back Pain/Injury <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer Other: _____	
Immunization Record					
* MMR (measles, mumps, rubella)					
Dose 1-Immunization at age 1		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Dose 2		<input type="checkbox"/> Yes <input type="checkbox"/> No			
* Tetanus-Diphtheria		<input type="checkbox"/> Yes <input type="checkbox"/> No			
* Year of last tetanus boost (must be within last 10 years)					
Has participant ever had major surgery or been hospitalized?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please explain any significant operations, accidents or illnesses, and last medical attention and reason:					
Does the participant have any physical condition(s) requiring special considerations? Explain.					
A physical examination within 24 months of the camp/event is recommended. Date of participant's last physical examination: _____					