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

I, _____ (print name), age _____, desire to voluntarily participate in _____ and associated activities and any recreational activities at the University of Wisconsin – River Falls.

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 JEANNA HAYES, RISK MANAGER, AT TELEPHONE NUMBER 715-425-3344.

Assumption of Risks:

I understand that participation in this volunteer activity, by its very nature, carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The specific risks vary from one activity to another, but in each activity the risks range from: 1) minor injuries such as scratches, bruises, and sprains to 2) major injuries such as fractures, internal injuries, joint or back injuries, heart attacks, and concussions to 3) catastrophic injuries including paralysis and death. I understand that the university has advised me to seek the advice of my physician before participating in this activity. I understand that I have been advised to have health and accident insurance in effect and that no such coverage is provided for me 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 permission for me to voluntarily participate in _____, today and on all future dates, I, for myself, my heirs, personal representatives or assigns**,** agree to defend, hold harmless, indemnify and release the Board of Regents of the University of Wisconsin System, the University of Wisconsin-River Falls, and their officers, employees, agents, and volunteers, 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/my child's 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-River Falls, 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-River Falls and its designated representatives to consent, on my/my child's 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:** _____

Medication
It is camp policy to secure your consent for medicine distribution and medical devices, whether brought by your son, daughter, or ward is to be self administered or administered by the camp health supervisor. Therefore, do you wish your son, daughter, or ward to be responsible for their own medication _____Yes _____No
If NO, all medications brought to camp by a camper shall be: (a) in containers which identify the medications and the name of the camper, (B) kept in a locked unit, and (c) administered by the camp health staff as prescribed by a licensed physician with a record of treatment maintained.

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 or through activities at the University of Wisconsin – River Falls, it is our policy to request your agreement to the above terms, on behalf of your minor son, daughter or ward.

University of Wisconsin – River Falls
2021 Youth Event Health Form

Event Name: _____

Dates: _____

Youth Name (include middle name): _____ Birth date __/__/____

Gender: ☐Male ☐Female Ethnicity: ☐Hispanic ☐Non-Hispanic Race: ☐African American ☐Asian ☐Native American ☐White ☐Other

Custodial Parent/Guardian (or spouse) _____ E-mail address: _____

Phone Numbers: Home (____) ____-____ Work (____) ____-____ Cell phone (____) ____-____

Home address: _____
Street City State Zip

Second parent/guardian
and/or emergency contact: _____ Phone: Home (____) ____-____
Work (____) ____-____

Address: _____
Street City State Zip

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 – River Falls, it is event/camp policy to secure your consent for **medication distribution and for the use of medical devices**. The medication or medical device must be administered by designated event/camp health staff with the exception that a limited amount of medication for life-threatening conditions may be carried by my son/daughter/ward (i.e. bee sting kit, inhaler, insulin syringe).

☐ Prescription medication(s) has been brought to event/camp. All prescription medication must be in the **original medicine bottle** (see picture at right) and labeled with the youth participant's name, doctor's name, medication name, dosage, prescription number, date prescribed, and instructions. Also, information about any prescription medications must be provided in writing to event/camp health staff with the information requested on the second page of this form.

☐ Over-the-counter medications have been brought to event/camp and may be administered by camp health staff as needed. All over-the-counter medications must be labeled with the youth participant's name, medication name, dosage, and instruction.

☐ No medication(s) has been brought to event/camp.

If your son, daughter, or ward will be under the age of 18 years while at the event/camp, it is our policy to secure your agreement to **all of the following** statements. By signing below:

- I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- I am stating that I am aware of and accept the risk inherent in the program activity.
- I attest that all information on both sides of this form is correct and up-to-date, and that **I will provide any and all significant, material, or important changes** to any information in this form to event/camp staff no later than check-in.
- I agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin – River Falls, their officers, agents, and employees from any and all liability, loss, damages, costs, or expenses which are sustained, incurred or required arising out of the actions of my son, daughter or ward in the course of the event/camp.

_____

Participant Name (Please Print)

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN **Date**

(Must complete reverse side)

UW - River Falls
Youth Event Health Form (Continued)

Participant Name: _____
Parent/Guardian Signature: _____

Health Conditions (check)

- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Psychiatric
- ☐ Cognitive/Developmental
- ☐ Any dizziness, light-headedness or fainting associated with exercise within the past year
- ☐ Any unexplained, rapid or irregular heart beat within the past year
- ☐ A physician has sometime denied or restricted participation in sports due to a heart problem

Allergies (check & list specifics)

- ☐ Insect stings _____
- ☐ Foods _____
- ☐ Medications _____
- ☐ Other _____

Do any allergies require an EPIPEN Injection? ☐ Yes ☐ No
Is an inhaler required and carried by youth? ☐ Yes ☐ No
Date of last Tetanus booster : _____

Name of Insurance Co.: _____ Policy #: _____

Description of any limitation or restriction of event activities:

_____

Any special accommodations regarding physical or emotional conditions that we need to be aware of regarding your child's participation in this event/camp (include circumstances when physician should be notified)?

_____

Medications camper will be taking at camp:

Name of Medication	Reason	Dosage (mg)	Times of day given	Prescribing Physician & Phone Number

1. Does the youth experience any side effects from the medication? (i.e., mood/behavior changes, upset stomach, diarrhea) ☐ Yes ☐ No

   _____

2. List any special instructions or additional information regarding the medication that would be helpful to the Health Care staff:

   _____

***** <u>FOR EVENT/CAMP USE ONLY</u> – TO BE COMPLETED BY HEALTH CARE STAFF AT CHECK-IN *****

1. Are there any changes in your child's health status since the medical forms were sent in? ❑ No ❑ Yes
2. Has your child, or anyone in your family been sick or exposed to any communicable disease in the past month? ❑ No ❑ Yes
3. Does your child now have any rashes or open sores? ❑ No ❑ Yes
4. Are there any changes in your dependent's medications? *(If **Yes**, Staff make changes . & sign)* ❑ No ❑ Yes
5. Does your child have any recent injury or activity restrictions? ❑ No ❑ Yes
6. Will the custodial parent(s) or guardian be available at the numbers listed on this form during the camping session? ❑ No ❑ Yes
   If NO, list the name & phone number of person(s) authorized to make decisions on their behalf if different than the emergency contact listed on the reverse side of this form:

Information provided by: _____ **To:** _____ **Date:** _____