

UW-Superior Student Organization Activities Waiver

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

I, _____ (print name), age _____, desire to participate voluntarily in the activity(ies) sponsored by **the World Student Organization** at the University of Wisconsin – Superior.

The activity I am participating in is: _____

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:

Student Organization Contact Name: Kim Habig or Tatiana Kornstad, WSA Advisor

Student Organization Contact Phone number: 715-394-8138

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 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 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 the UW-Superior Explore the Twin Ports 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.

Informed Consent / Medical History & Photo Release

The University of Wisconsin – Superior Explore the Twin Ports program involves a variety of activities that may include warm-ups, games, group initiative problems, trust experiences, and other rigorous physical adventure activities, exposure to the elements as well as nature (insects, plants, etc.). Participation in a University of Wisconsin – Superior’s program and its activities is at all times an individual choice. There are risks, which must be assumed by each participant, that he or she may suffer an emotional or physical injury or disability.

The University of Wisconsin – Superior activities requires that every participant provide certain health/medical information to the coordinators of the activity so that they are prepared to assist the participant in getting the appropriate medical attention/services should the need arise. The following information will be held in confidence. Please complete the form and return it to the coordinators of the activity prior to participating in any activities.

Date(s) of Workshop(s): _____

PHOTO/MEDIA RELEASE

Sign if you DO grant to the University of Wisconsin Superior the right to use, reproduce, assign and/or distribute photographs, films, videotapes, and sound recordings of you/your child for use in materials they may create.

Signature of Applicant: _____

Signature of Parent or Guardian (if under 18): _____

UW-SUPERIOR HEALTH HISTORY QUESTIONNAIRE

Full Participant Name:		Event Name:		Event 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 _____	
Emergency contact in the event of 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 _____	
Physician: _____ Telephone: _____		Insurance Co.: _____ Policy No.: _____		Has participant had or presently experiencing:	
Does the participant have any physical condition(s) requiring special considerations? Explain.				<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: _____	

*Required if participant is under the age of 18 years.