

**UNIVERSITY OF WISCONSIN-LA CROSSE**  
**UW-L Club Sports**  
***RISK AND LIABILITY RELEASE***

Name of Club: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Local Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Year in School                        
                             FR      SO      JR      SR      GRAD

**STATEMENT OF RISKS AND LIABILITY RELEASE FOR CLUB PARTICIPATION**

IMPORTANT NOTE: BEFORE SIGNING, READ CAREFULLY THE FOLLOWING STATEMENTS. DO NOT SIGN UNTIL YOU FULLY UNDERSTAND THE STATEMENT AND RISKS OF PARTICIPATION IN THIS CLUB. IF YOU HAVE QUESTIONS, DO NOT HESITATE TO ASK THE CLUB SPORTS OFFIERS OR ADVISOR.

I, \_\_\_\_\_, being 18 years of age or older and my heirs in consideration for being allowed to participate in the activities and competition of the \_\_\_\_\_ hereby RELEASE, FOREVER DISCHARGE, AND AGREE NOT TO SUE, the state of Wisconsin, the officers and advisors of said Club, University of Wisconsin-La Crosse, and all its employees and officers, from liability for any damage to, or loss of personal property, sickness, and injury from whatever source, legal entanglements, imprisonment, death, loss of money, etc., which might occur during my involvement and participation in the activities and competitions of the aforementioned club. I ALSO HEREBY WAIVE ALL SUCH CLAIMS WHICH I HAVE NOW OR MAY HEREAFTER HAVE AGAINST ABOVE ORGANIZATIONS OR PERSONS, HOWEVER CAUSED. I have read and understand the above. Initial here: \_\_\_\_\_

Your signature below agrees to the following: I acknowledge that I am acquainted with the dangers and risks of my physical being, when I participate in outdoor or indoor physical activities. I also am of the appropriate skill level and physical condition to undertake the rigors or participating in the above mentioned club. If I have any doubts regarding my medical or physical condition, I will seek medical advice. I have made a careful decision and I am willing to accept all risks. I have read and understood the above. Initial here: \_\_\_\_\_

Additionally, I understand that if I drive my own vehicle, I am responsible for my actions as well as providing proper insurance. I understand that neither UWL nor Club Sports is responsible for the safety of personal vehicles, nor does it provide insurance. I also understand that personal medical insurance is not provided and I am responsible for obtaining proper personal insurance coverage. I have read and understand the above. Initial here: \_\_\_\_\_

I agree for myself and my successors, that the above representations and agreements are contractually binding, and not mere recitals. I agree that my failure or refusal to sign other such agreements or releases shall in no way affect the validity of this agreement, nor revoke or cancel any of the terms of this claim or bring any suit in violation of this agreement. I or any of my successors shall be liable for the expense (including legal fees) incurred by the other party or parties defending against such claim or suit. This agreement may not be modified orally. I have read and understand the above. Initial here: \_\_\_\_\_

I also hereby grant the Recreational Sports program permission to utilize my likeness for use by television, films or printed media to further the aims of the program and release them from any/all claims in its use. \_\_\_\_\_

I HAVE CAREFULLY READ THIS FORM AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THIS IS A RELEASE OF LIABILITY, A WAIVER OF CLAIMS, AN AGREEMENT NOT TO SUE, AND A CONTRACT BETWEEN MYSELF AND UW-LA CROSSE, AND FOR THE BENEFIT OF OTHERS DESCRIBED HEREIN, I SIGN IT OF MY OWN FREE WILL. I have read and understand the above.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

UNIVERSITY OF WISCONSIN-LA CROSSE  
UW-L CLUB SPORTS  
**MEDICAL QUESTIONNAIRE AND RELEASE**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

SS # \_\_\_\_\_ Student ID # \_\_\_\_\_

\*MEDICATION CURRENTLY TAKING: \_\_\_\_\_ Amount: \_\_\_\_ Frequency \_\_\_\_

**IN CASE OF EMERGENCY NOTIFY:**

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Phone Number: (\_\_\_\_) \_\_\_\_\_

Parents Name \_\_\_\_\_ Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_

Date of Last Physical Examination: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Policy: \_\_\_\_\_

Health Policy Number: \_\_\_\_\_

\*NOTE: All participants are required to maintain health insurance through either University, family, group, or individual plans.

HEALTH HISTORY: To the best of your knowledge, check off all health conditions below, which you have contracted in the past three years.

Frequent Ear Infections: \_\_\_\_\_ Mononucleosis: \_\_\_\_\_ Hay Fever: \_\_\_\_\_

Convulsions: \_\_\_\_\_ Chicken Pox: \_\_\_\_\_ Poison Ivy: \_\_\_\_\_

Diabetes: \_\_\_\_\_ Measles: \_\_\_\_\_ Insect Sting: \_\_\_\_\_

Hypertension: \_\_\_\_\_ German measles: \_\_\_\_\_ Asthma: \_\_\_\_\_

Bleeding/Clotting Disorders: \_\_\_\_\_

List Any Operations or Serious Injuries (include approximate dates): \_\_\_\_\_

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List Any Disability or Chronic or Recurring Illness: \_\_\_\_\_

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Does signer have Epilepsy: \_\_\_\_\_ Does signer have Diabetes: \_\_\_\_\_

Indicate Any Further Health Related Information that should be known by the Univeristy:

**IMPORTANT: THE FOLLOWING MUST BE COMPLETED FOR PARTICIPATION**

The above health history is correct so far as I know. I hereby give permission to the medical personnel selected by the club leader at hand, to order X-rays, routine tests and treatment for me, and in the event that my indicated emergency contact person can not be notified in an emergency, I hereby give permission to the physician selected by the club leader, to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for me. This form may be photocopied for use.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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