Agreement for Indemnification, Release, and Consent for Emergency Treatment

Description of Activity	**Marching Band**
Name & phone number of UW-L Representative	**Dr. Tammy Fisher** **608.785.6725**

I, _____ (print name), age _____, desire to participate voluntarily in the above-described activity at the University of Wisconsin–La Crosse.

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 THE ABOVE-NAMED UW-L REPRESENTATIVE.

Hold Harmless, Indemnity and Release:

In consideration of permission for me to voluntarily participate in the above-described activity, 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–La Crosse, 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 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, University of Wisconsin–La Crosse, 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 of Participant: _____ **Date:** _____

Signature of Parent or Guardian (if Participant is Under 18): _____ **Date:** _____

Consent for Emergency Treatment:

I authorize University of Wisconsin–La Crosse 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 of Participant: _____ **Date:** _____

Signature of Parent or Guardian (if Participant is Under 18): _____ **Date:** _____

Provide information on any medical condition for which you are currently being treated:

Provide any additional medical information (e.g., allergies, prescriptions, dietary restrictions, etc.):

Emergency Contacts: In the case of an emergency, I authorize the UW-La Crosse Representative to contact the following contact persons:

Name _____ Relationship _____

Address _____

Home Phone ( ) _____ Work Phone ( ) _____

Name _____ Relationship _____

Address _____

Home Phone ( ) _____ Work Phone ( ) _____

This is to certify that I am covered by a health and accident insurance policy for the duration of my travel as a participant in the above-named program. This insurance is provided through:

Insurance Company_____

Policy Number_____

Signature of Participant _____ Date _____

Signature of Parent/Guardian _____ Date _____ (required if participant is under 18 years of age)