

RELEASE OF LIABILITY, ASSUMPTION OF RISKS AND AGREEMENT TO PAY CLAIMS

Event Date(s) and Time(s): _____

Event Location: _____

Event: _____

RELEASE OF LIABILITY

In return for being allowed to participate in this Event, I release from liability and agree not to sue the State of California, the Trustees of The California State University, California State University, Fullerton and their employees, officers, volunteers and agents for any claim for any personal or bodily injury, including death, or property damage I may suffer while participating in this Event or any incidental activity, including flying on an airplane.

I understand I am releasing the State of California, the Trustees of The California State University, California State University, Fullerton and their respective employees, officers, volunteers and agents from all liability for any injury, death or property damage caused by participating in this Event or any incidental activity, including flying on an airplane.

ASSUMPTION OF RISK

I am voluntarily participating in this Event, which I know requires air travel. I am have been informed of the risks associated with this Event or any related activity, including air travel; unpredictable weather conditions; conditions of equipment used; language barriers; different legal systems, medical standards and social cultures; sickness; strikes; natural disasters; civil unrest or hostilities; terrorist activities; or acts of war. I understand that these risks may result in personal or bodily injury, including death, or property damage. **Nonetheless, I assume all risks, whether known or unknown to me, of participating in this Event or any activity incidental to the Event, including air travel.**

AGREEMENT TO PAY CLAIMS

I agree that I will pay any award, cost or settlement demanded from the State of California, the Trustees of The California State University, California State University, Fullerton and their employees, officers, volunteers and agents as a result of any claim arising out of my participation in this Event or any activity incidental to the Event, including air travel.

AGREEMENT TO PAY MEDICAL EXPENSES

I am in good health and able to participate in this Event. If I need medical treatment and my emergency contact cannot be reached, I agree to any treatment deemed advisable by any licensed emergency or medical personnel and to be financially responsible for any costs incurred as a result of such treatment. Although I have purchased travel insurance through the University, I understand that I should also carry health insurance of my own.

I understand that I am responsible while participating in the Event for arranging for the continuation of any medical treatments such as prescriptions or special diets I may require. I also understand and acknowledge that healthcare facilities at the Event site may be minimal/absent and that all types of health care, including for emergencies, may be difficult to find.

ACKNOWLEDGEMENT OF UNDERSTANDING

I am 18 years old or older. I have read this two-sided document, and I am signing it freely. I understand the legal consequences of signing this document, including my (a) release of all liability, (b) waiver of my right to sue and (c) assumption of all risks of participating in this Event or any activity incidental to the Event, including air travel. No oral promises have been made to me to sign this document.

I understand that this document has been written to be as broad and inclusive as legally permitted. I agree that if any portion is held invalid or unenforceable, I will continue to be bound by the remaining terms.

Name: _____ Birth Date: _____

Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____
(Required if participant is under 18 years of age)

EMERGENCY CONTACT AND MEDICAL INFORMATION

Primary Contact

Secondary Contact

Name: _____ Name: _____

Relation: _____ Relation: _____

Daytime Phone: () _____ Daytime Phone: () _____

Evening Phone: () _____ Evening Phone: () _____

Please list all:

Allergies: _____

Current Medications: _____

Medical Conditions: (special diets, treatments, etc.) _____

Do you have health insurance? Yes No Name of Health Care Provider: _____