Assumption of Risk and Release from Liability ("Agreement")

I, the undersigned, give permission for my Child to participate in PHYSICS SHOWDOWN AT IU (PSIU) offered on behalf of The Board of Trustees of Indiana University ("IU"), at IU DEPARTMENT OF PHYSICS, 727 E. Third St., Swain Hall West, Bloomington, IN 47405-7105 on SATURDAY, JANUARY 23, 2016.

In consideration for my Child’s participation, I, on behalf of my Child, agree to the following:

1. I understand the Program consists of the following activities: [Fill in as appropriate. Examples: a kickball tournament, riding in University vehicles, participating in sporting or academic events or activities, daily camp activities, etc.]

2. I understand that as part of my Child’s participation in the Program there are dangers, hazards, and inherent risks to which my Child may be exposed, including, but not limited to, the risk of serious physical injury, temporary or permanent disability, and death, as well as economic and property loss. I further understand that participating in the Program may involve other risks and dangers, whether known or unknown nor reasonably foreseeable, including the following: [Fill in as appropriate. Example: drowning, food/drink allergies, specific injuries (e.g. sprains, cuts, bruises), etc.]

3. I fully understand the scope of the activities and the risks involved. I voluntarily accept and assume all risks of injury, loss of life, or damage to property arising out of my Child’s participation in the Program.

4. I hereby release and fully discharge IU, including its officers, employees, and agents, from any and all claims or causes of action, including all liability for damage to personal property or personal injury which may result from my Child’s participation in the Program, that may be brought by me or my Child or for any injury or loss that my Child may suffer while participating in the Event, whether caused by negligence or otherwise, to the fullest extent permitted by law.

5. I further release, indemnify, and hold harmless IU, including its officers, employees, and agents, from and against any and all liability, actions, debts, claims, and demands of every kind whatsoever, including, but not limited to, any claim for negligence and/or any present or future claim, loss, or liability for which my Child may be liable to any other person or to IU that arises out of my Child’s participation in the Program.

6. In the event of an accident or serious illness, I hereby authorize representatives of IU to obtain medical treatment and transport for my Child on my behalf. I waive my right to receive informed consent prior to such transportation or treatment. I hereby hold harmless and agree to indemnify IU from any claims, causes of action, damages and/or liabilities, arising out of or resulting from the medical treatment or transport. I further agree to accept full responsibility for any and all expenses, including medical expenses that may derive from any injuries to my Child that may occur during his/her participation in the Program.

7. This Agreement shall be governed by and construed under the laws of Indiana. Notwithstanding any other agreement that I have signed related to this Program that purports to establish the venue for any litigation arising from this Program, I agree that I will file no action against The Trustees of Indiana University or its officers, employees, and agents, whether based on this Agreement or in any way otherwise connected to this Program, in any court other than the Circuit Court of Monroe County, Indiana.

8. I understand and agree to all of the terms of this Agreement. I understand that I am giving up substantial rights (including my right to sue) and acknowledge that I am willingly signing this document. My signature on this document is intended to bind not only myself and my Child, but also the successors, heirs, representatives, administrators, and assigns of myself and my Child.

___________________________
Child’s name

___________________________
Parent/guardian signature

___________________________
Parent/guardian name

___________________________
Date
Consent for Medical Treatment (minors only)

I, ____________________________, am the parent or legal guardian of ____________________________ and I authorize ____________________________ to obtain emergency medical treatment of this minor by an appropriate health care professional should the need arise while he/she is attending the program.

Signature ____________________________ Date ____________________________

Medical Information (all participants)

Participant’s name ____________________________ Age ____________________________ Birthdate ____________________________

Date of last Tetanus Toxoid ____________________________ Past health/injuries ____________________________

Present health ____________________________

Allergies to medications: ____________________________________________

Allergies to food: ____________________________________________

Other Allergies: ____________________________________________

Present medications: ____________________________________________

Check here if the participant has special needs and might require accommodations to fully participate in the program. A staff member will contact the parent or guardian for details.

Other information that would be useful in the event medical treatment is necessary: ____________________________________________

Insurance Information (all participants)

Parents or legal guardians are responsible for the cost of a minor’s medical treatment. When available, insurance information will be processed by the health facility performing the treatment, otherwise you will be contacted for payment by cash, check or credit card.

Insurance company ____________________________ Address ____________________________

City/State/Zip ____________________________

Policyholder’s name ____________________________

Policy number ____________________________

Contact People (all participants)

In an emergency, parents or legal guardians can be reached as follows:

Name ____________________________ Relationship to minor ____________________________

Address ____________________________ Daytime phone ____________________________

City/State/Zip ____________________________ Evening phone ____________________________

Cell phone ____________________________

Name ____________________________ Relationship to minor ____________________________

Address ____________________________ Daytime phone ____________________________

City/State/Zip ____________________________ Evening phone ____________________________

Cell phone ____________________________

If other information would be helpful in contacting you, please indicate:
TALENT CONSENT FORM
OFFICE OF SCIENCE OUTREACH

I grant permission to the directors, assistants, or other persons associated with Indiana University Office of Science Outreach and IU Department of Physics to use images of me.

I understand that, if used, these images will be employed to promote Indiana University and Science Outreach.

I give my consent to the conditions that have been stated above.

Date: _________________

Participant Name (print): ________________________________

Participant Signature: ____________________________________

For children under the age of 18, a parent or guardian consent is required.

Date: _________________

Parent Name (print) ______________________________________

Parent’s Signature: _______________________________________

For Office Use Only:

Event Taken: ___________________________ Date:

Activity: ______________________________

Quote From Participant: