AGREEMENT FOR ADULT PARTICIPATION IN VOLUNTARY ACTIVITY
AND AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Name of volunteer/participant: _____ Phone #_____
(Please print)

Specific nature of activity/event: _____

Date of activity: _____Time of activity: _____

Person in charge: _____

I understand and agree that in return for this waiver and the other promises herein [School] will permit me to participate in the voluntary activity described above.

I fully understand that volunteers/participants are to abide by all rules and regulations governing conduct as directed by [School] during the activity.

ASSUMPTION OF RISK AND WAIVER OF LIABILITY:

It is further agreed that the undersigned is fully aware of the nature and extent of the potential hazards of [Activity/Event], and agrees that [School] shall not be responsible or liable for any and all injuries sustained by me, or for any loss, damage or expense arising out of my voluntary participation. As a volunteer, I understand that no compensation is expected in return for services I may contribute and that [School] will not provide any benefits traditionally associated with employment, such as workers' compensation, health or accident insurance. In the event of personal injury or illness, I am responsible for my own costs, damages and expenses.

With respect to my participation in this activity/event, I release, hold harmless and waive all claims against [School], its officers, agents, employees, volunteers; the School District; and the State of California without regard to negligence. I have no question regarding the scope or intent of this agreement, and have the right and authority to bind myself and any other family member, personal representative, assign, heir, trustee, or guardian to the terms herein.

X_____
Signature of Volunteer/Participant

EMERGENCY MEDICAL TREATMENT AUTHORIZATION
In the event of illness or injury, I do herby consent to whatever x-ray, examination, anesthetic, medical, surgical, dental diagnosis/treatment, hospital care and emergency transportation may be considered necessary in the best judgment of the attending physician, surgeon or dentist.

X_____
Signature of Volunteer/Participant

Medical Insurance Carrier and Policy or Group Number: _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____