

**BY SIGNING THIS DOCUMENT, YOU ARE WAIVING CERTAIN LEGAL RIGHTS.  
PLEASE READ THIS DOCUMENT CAREFULLY BEFORE SIGNING.**

**TRINITY UNIVERSITY  
PROGRAM RELEASE, INDEMNITY AND MEDICAL CONSENT AGREEMENT**

Printed Name of Participant: \_\_\_\_\_

Program: \_\_\_\_\_

Participant Date of Birth: \_\_\_\_\_ Dates of Program: \_\_\_\_\_

**ELECTIVE PARTICIPATION**

I, (or on behalf of my minor child) hereby acknowledge that Participant has voluntarily elected to enroll in the above Program ("Program") to be held at Trinity University. I acknowledge that my participation (or enrollment of my minor child) is elective and voluntary. **As a condition of my participation, I hereby grant Trinity University the right to use, for promotional purposes only, any photographs of me taken by Trinity University, its employees or agents, during my participation in the Program. I further understand and agree that Trinity University may use (for marketing purposes) any statements or quotes attributed to me in my evaluation of the Program.**

**RULES AND REQUIREMENTS**

I agree to conduct myself in accordance with Trinity University policies and procedures that are applicable to the Program at Trinity University. I further agree to abide by all of the rules and requirements of each activity within the Program. If my minor child is the Participant, I agree to ensure that he/she abides by all of the rules and requirements of each activity and the Program. I understand that Trinity University has the right to terminate my/my minor child's participation in the Program if it is determined that my/my minor child's conduct is detrimental to the best interests of the group, violates any rule of the Program or for any other reason in Trinity University's discretion.

**INFORMED CONSENT/ASSUMPTION OF RISK**

I have been informed of and I understand the various aspects of the Program. I understand and agree that I/my minor child will engage in physical activities, including water-sports activities, which may pose a risk of harm. I understand that these activities include but are not limited to: playing, observing or participating in Program activities. I further understand and agree that the risks involved this Program are both water and land based. By participating, I/my minor child could sustain serious personal injuries, illness, infectious disease, property damage or even death as a consequence of not only Trinity University's actions or inactions, but also the actions, inactions, negligence or fault of others, the conditions of equipment used, facility conditions, weather conditions, negligent first aid operations and procedures and I understand that there may be other risks not known to me or not reasonably foreseeable at this time. I further understand and agree that any injury, illness, infectious disease, property damage, disability or death that I/my minor child may sustain by any means is my sole responsibility except for those occurrences due to Trinity University's gross negligence or intentional acts.

**I KNOWINGLY AND VOLUNTARILY ASSUME ALL SUCH RISKS, BOTH KNOWN AND UNKNOWN, EVEN IF ARISING FROM THE ACTS OF THE RELEASEES, UNLESS THEY ARISE FROM THE RELEASEES' INTENTIONAL OR GROSSLY NEGLIGENT ACTS, and assume full responsibility for my/my minor child's participation in the Program.**

**RELEASE AND WAIVER OF LIABILITY**

I, on behalf of myself, my personal representatives, heirs, executors, administrators, agents and assigns, **HEREBY FULLY RELEASE, WAIVE, DISCHARGE, COVENANT NOT TO SUE AND HOLD HARMLESS** Trinity University, its governing board, trustees, officers, employees, agents, contractors and volunteers (hereinafter referred to as "Releasees") from and against any and all losses, damages, liabilities, costs, expenses, claims, demands, causes of action, suits or other litigation (including all costs thereof and attorneys' fees) of every kind and character arising directly or indirectly out of or in connection with my participation in the Program, my use of Trinity University's campus or facilities, and/or any action or inaction by Trinity university and its trustees, officers, employees, agents, contractors and volunteers relating to me and any oversight or care for me. **IT IS MY EXPRESS INTENTION THAT THIS WAIVER, RELEASE, DISCHARGE, COVENANT NOT TO SUE, AND HOLD HARMLESS SHALL INCLUDE, BUT SHALL NOT BE LIMITED TO, ALL LIABILITY, COST, EXPENSES, CLAIMS, CAUSES OF ACTION, AND/OR DAMAGES ATTRIBUTABLE TO OR CAUSED IN ANY WAY BY ANY NEGLIGENT ACT OR OMISSION OF FAULT BY THE UNIVERSITY AND/OR ITS OFFICERS, TRUSTEES, AGENTS, VOLUNTEERS, CONTRACTORS, REPRESENTATIVES, OR EMPLOYEES.**

**It is my express intention that this Agreement be binding on the members of my family, my heirs, assigns, and personal representative, and shall be deemed as a WAIVER, RELEASE OF LIABILITY, DISCHARGE, HOLD HARMLESS, ASSUMPTION OF RISK, and COVENANT NOT TO SUE the University.**

#### **INDEMNITY**

I, on behalf of myself, my personal representatives, heirs, executors, administrators, agents and assigns, agree to defend, indemnify and hold harmless the Releasees from any and all liability, including any and all claims, demands, causes of action (known or unknown), suits, or judgments of any and every kind (including attorneys' fees), arising from any injury, illness, infectious disease, property damage or death that I/my minor child may suffer as a result of my/my minor child's participation in the Program, **REGARDLESS OF WHETHER THE INJURY, DAMAGE OR DEATH IS CAUSED BY THE RELEASEES OR OTHERWISE, UNLESS THE INJURY DAMAGE OR DEATH IS CAUSED BY THE RELEASEES' GROSS NEGLIGENCE OR INTENTIONAL ACTS.**

#### **PERSONAL MEDICAL INSURANCE**

I understand that I am responsible for purchasing my own medical insurance. Further, I acknowledge that I am responsible for the cost of any and all medical and health services I/my minor child may require as a result of participating in the Program.

#### **MEDICAL CONSENT**

For, and in consideration of being permitted to participate in the Program at Trinity University, I hereby give the Program, Trinity University and its instructors, sponsors, agents, employees, officers, trustees and affiliates authority to provide me with whatever medical treatment that the Program or Trinity University may consider appropriate under the circumstances, including, but not limited to, authority to authorize medical tests, transfusions, injections, surgery and other medical treatment by any physician, surgeon, medical personnel and/or medical facility. I fully recognize that injury or illness could result from or during my participation in the Program. I understand and agree that Releasee's may not have medical personnel available at the location of the program. In the event of any medical emergency, I (initial one) do \_\_\_\_\_ do not \_\_\_\_\_ authorize and consent to any x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment, and hospital care that Trinity University personnel deem necessary for my/my minor child's safety and protection. I authorize the Program or Trinity University, at its discretion, to place me, at my own and my parents' or legal guardians' expense, and without further consent, in a hospital, clinic or other medical facility for medical services and treatment. I understand and agree that Releasees assume no responsibility for any injury or damage which may arise out of or in connection with such authorized emergency medical treatment. I understand that I am responsible for any and all medical expenses incurred by me in connection with my participation in the Program, including but not limited to expenses incurred by me for transportation to a medical facility and expenses for private follow-up care.

#### **CERTIFICATION OF FITNESS TO PARTICIPATE**

I attest that I/my minor child am/is physically and mentally fit to participate in the Program and that I/my minor child do not have any medical record of history that could be aggravated by my participation in the Program.

#### **CHOICE OF LAW**

I hereby agree that this Agreement shall be construed in accordance with the laws of the State of Texas.

#### **SEVERABILITY**

If any term or provision of this Agreement shall be held illegal, unenforceable, or in conflict with any law governing this Agreement, the validity of the remaining portions shall not be affected thereby.

**I hereby acknowledge that I have read, understand and will abide by each of the terms and conditions of this Agreement.**

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

Signature of Participant \_\_\_\_\_

Printed Name of Participant: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Day Phone: \_\_\_\_\_

**Signature of Parent/Guardian for Participants Who Are Minors:**

I certify that I have custody of Participant or am the legal guardian of Participant by court order. I HAVE READ THIS AGREEMENT AND FULLY UNDERSTAND AND AGREE TO ITS TERMS. **I AM AWARE THAT THIS AGREEMENT INCLUDES A RELEASE AND WAIVER OF LIABILITY, AN ASSUMPTION OF RISK AND AN AGREEMENT TO INDEMNIFY TRINITY UNIVERSITY.**

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

Signature of Parent or Guardian: \_\_\_\_\_

Printed Name of Parent or Guardian: \_\_\_\_\_

**Received By:**

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

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

Printed Name of Institution Official: \_\_\_\_\_

# EMERGENCY MEDICAL TREATMENT INFORMATION FORM

1. Please list any chronic or acute medical conditions of Participant (if none, please put N/A):
2. Please identify all known allergies of Participant to foods, medicines, insect bites, etc., and the nature of his/her reaction (if none, please put N/A):
3. If Participant is presently taking medication, please identify the medication and, if you choose, the reason for its use (if none, please put N/A):

4. Date of last tetanus injection: \_\_\_\_\_

5. Participant's Health Insurance Information:

Name of Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Medical Insurance Policy Number: \_\_\_\_\_

6. Does the Participant suffer from any of the following?

Nosebleeds \_\_\_\_\_ Rupture \_\_\_\_\_ Ear Aches \_\_\_\_\_ Stomach Cramps \_\_\_\_\_ Heart Exhaustion \_\_\_\_\_

Epilepsy \_\_\_\_\_ Heart Condition \_\_\_\_\_ Sore Throat \_\_\_\_\_ Diabetes \_\_\_\_\_

7. Has the Participant been hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

8. Please check if Participant has had any of the following:

Mumps \_\_\_\_\_ Measles \_\_\_\_\_ Polio \_\_\_\_\_ Chicken Pox \_\_\_\_\_

9. In case of emergency, the following persons should be contacted:

Father's Name: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

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

City: \_\_\_\_\_

Mother's Day Phone: \_\_\_\_\_

Father's Day Phone: \_\_\_\_\_

Mother's Alternative/Cell Phone: \_\_\_\_\_

Father's Alternative/Cell Phone: \_\_\_\_\_

Legal Guardian/Spouse/Other Person to Contact in an Emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_

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

Day Phone: \_\_\_\_\_

Alternative/Cell Phone \_\_\_\_\_

10: Family Physical Information: \_\_\_\_\_

Name of Family Physician \_\_\_\_\_

Address of Family Physician \_\_\_\_\_

Telephone of Family Physician \_\_\_\_\_

Parent or Guardian's Signature \_\_\_\_\_

Telephone Number \_\_\_\_\_

Email Address \_\_\_\_\_

# TRINITY UNIVERSITY PROGRAM RELEASE

Name of Participant: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: (if different from above): \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_ Home Telephone Number: \_\_\_\_\_

**In addition to myself, you may release the participant named above to the following person(s):**

1. Name: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email: \_\_\_\_\_

2. Name: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_\_\_  
PRINTED NAME – PARENT/GUARDIAN

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

Participants will not be released to any person who is not listed above unless they know this  
PASSWORD: \_\_\_\_\_