Agreement for Assumption of Risk

I, (print name), age , desire to participate

voluntarily in at the University of Wisconsin – Madison

on

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 UW ATHLETICS AT TELEPHONE NUMBER (608) 262-1866 OR BY EMAIL AT CONTACTUS@UWBADGERS.COM.

Assumption of Risks:

I understand that physical activity and participation related to , by its very nature, carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries and illnesses. Some of these involve strenuous exertions of strength using various muscle groups, some involve quick movement involving speed and change of direction, and others involve sustained physical activity which places stress on the cardiovascular system, and exposure to infectious disease. The specific risks vary from one activity to another, but in each activity the risks range from: 1) minor injuries and illness such as scratches, bruises, and sprains, to 2) major injuries and illnesses such as fractures, internal injuries, joint or back injuries, heart attacks, concussions, and severe illness, to 3) catastrophic injuries and illnesses including paralysis and death. I understand that the University of Wisconsin-Madison has advised me to seek the advice of my physician before participating in this activity. I understand that I have been advised to have health and accident insurance in effect and that no such coverage is provided for me by the University or the State of Wisconsin. **I KNOW, UNDERSTAND, AND APPRECIATE THE RISKS THAT ARE INHERENT IN THE ABOVE-LISTED PROGRAMS AND ACTIVITIES. I HEREBY ASSERT THAT MY PARTICIPATION IS VOLUNTARY AND THAT I KNOWINGLY ASSUME ALL SUCH RISKS.**

Signature:____ **Date:** ______________________

Consent for Emergency Treatment:

I authorize the University of Wisconsin-Madison 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:____ **Date:** ______________________

Name and Signature of Parent or Guardian (if Participant is under 18)

Name (please print) ____

Signature:____ **Date:** ______________________