Agreement for Indemnification, Release, and Consent for Emergency Treatment.

Description of Activity	
Participant Name	
Participant Contact Number	

I, _____(print name), age _____, desire to participate voluntarily in the above-described activity organized by Multicultural Student Services, as part of the Division of Access, Belonging, and Compliance at the University of Wisconsin–La Crosse.

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 THE ABOVE-NAMED REPRESENTATIVE.

Hold Harmless, Indemnity and Release:

In consideration of permission for me to voluntarily participate in the above-described activity, today and on all future dates, I, for myself, my heirs, personal representatives or assigns**,** agree to defend, hold harmless, indemnify and release the UWL Multicultural Student Services and Division of Access, Belonging, and Compliance, the Board of Regents of the University of Wisconsin System, the University of Wisconsin–La Crosse, and their officers, employees, agents, and volunteers, from and against any and all claims, demands, actions, or causes of action of any sort on account of damage to personal property, or personal injury, or death which may result from my participation in the above-listed program. This release includes claims based on the negligence of Multicultural Student Services, Student Support Services, the Board of Regents of the University of Wisconsin System, University of Wisconsin–La Crosse, and their officers, employees, agents, and volunteers, but expressly does not include claims based on their intentional misconduct or gross negligence. **I understand that by agreeing to this clause I am releasing claims and giving up substantial rights, including my right to sue.**

Signature of Participant: _____ Date: _____

Consent for Emergency Treatment:

I authorize UWL's Multicultural Student Services designated representatives or the University of Wisconsin–La Crosse 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**

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Signature of Participant: _____ Date: _____

Emergency Contact Name: _____ Phone Number:_____

Relationship:_____