



WAIVER, RELEASE AND INDEMNITY AGREEMENT
ASSUMPTION OF RISK FOR PARTICIPATION IN VOLUNTARY ACTIVITY
MEDICAL TREATMENT AUTHORIZATION

Activity _____ Date(s) _____

Participant _____

In consideration for being allowed to participate in this Activity, I release from liability and waive my right to sue Palomar Community College District, their employees, officers, volunteers and agents (collectively "District") from any and all claims, resulting in any physical injury, illness (including death) or economic loss I may suffer or which may result from my participation in this Activity, travel to and from the Activity, or any events incidental to this Activity.

I am voluntarily participating in this Activity. I understand that there are risks associated with my participation in this Activity, such as physical and/or psychological injury, pain, suffering, illness, disfigurement, temporary or permanent disability, death or economic loss. These injuries or outcomes may arise from my own or other's actions, inactions, or negligence, or the condition of the Activity location (s) or facility (ies). Nonetheless, I assume all risks of my participation in this Activity, whether known or unknown to me, including travel to and from the Activity or any events incidental to this Activity.

I agree to hold the District harmless from any and all claims, loss or damage to my personal property, liabilities and costs, including attorney's fees, as a result of my participation in this Activity, including travel to and from the Activity or any events incidental to this Activity. If the District incurs any of these types of expenses, I agree to reimburse the District.

I have read this document, and I am signing it freely. I understand the legal consequences of signing this document, including (a) releasing the District from all liability, (b) waiving my right to sue the District, (c) and assuming all risks of participating in this Activity, including travel to and from the Activity or any events incidental to this Activity.

If I need medical treatment as a result of my participation in this Activity, travel to and from the Activity, or any events incidental to this Activity, I agree to be financially responsible for any costs incurred as a result of such treatment. I am aware that the District does not provide health insurance for me and that I should carry my own health insurance.

Participant's Signature Date Home Telephone No.

Parent/Guardian Signature (Required if Participant under age 18) Parent/Guardian Name (Print Clearly)

Family Medical Insurance Carrier: _____
(e.g., Blue Cross) Policy #

In the event of an emergency, please contact:

Name Relationship Phone No.