**Arrowhead Target Wellness Challenge Ropes Course & Indoor Climbing Wall Program**

# Agreement for Assumption of Risk, Indemnification, Release, and Consent for Emergency Treatment

I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (print name), age \_\_\_\_\_\_\_, desire to participate voluntarily in the Arrowhead Target Wellness Challenge Ropes Course & Indoor Climbing Wall Program at Arrowhead Union High School.

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:

Arrowhead Union High School, AT TELEPHONE NUMBER: 262-369-3612

**Assumption of Risks:**

I understand that not all risks can be foreseen and there are some risks which are unpredictable. I understand that certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. I am aware of the risks of participation, which include, but are not limited to, the possibility of physical injury, fatigue, bruises, contusions, broken bones, concussion, paralysis, and even death. I understand that Arrowhead has advised me to seek the advice of my physician before participating in the Arrowhead Target Wellness Challenge Ropes Course & Indoor Climbing Wall Program. 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 Arrowhead High School 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Hold Harmless, Indemnity, and Release**:

In consideration of my participation in these activities, I, for myself, spouse, heirs, personal representatives, estate or assigns**,** agree to defend, hold harmless, indemnify and release Arrowhead Union High School, and their officers, employees, agents, volunteers, and all others who are involved, 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 Arrowhead Union High School, 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Consent for Emergency Treatment:**

I authorize Arrowhead Union High School 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Additional information can be obtained from the Arrowhead Physical Education Website at** [**www.arrowheadschools.org**](http://www.arrowheadschools.org)

**Arrowhead Target Wellness Challenge Ropes Course &**

**Indoor Climbing Wall Program**

**Informed Consent / Medical History & Photo Release**

Our program involves a variety of activities that often include warm-ups, games, group initiative problems, trust experiences, low / high elements, and other rigorous physical adventure activities. Participation in our program and its activities is at all times an individual choice. There are risks, which must be assumed by each participant, that he or she may suffer an emotional or physical injury or disability.

Our policy requires that every participant provide certain health/medical information to the instructor(s) so that they are prepared to help participants make informed choices about their level of participation.

The following information will be held in confidence. Please complete the form and return it to the facilitator/instructor prior to participating in any activities.

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPLICANT INFORMATION:**

1. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

2. Do you have any health/accident insurance? \_\_\_no \_\_\_yes If yes, name, and address of company:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INFORMATION**:

**NOTE: In the interest of trying to provide a successful experience for all participants we ask that you take the time to answer the following questions. This information will be kept in confidence by Arrowhead Union High School and only shared with your permission.**

1. Do you have any limiting physical or health disabilities (temporary or permanent)? \_\_no \_\_yes If yes, identify and explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you currently take medication (prescribed or otherwise, e.g. cold medicine)? \_\_no \_\_yes If yes, what are you taking, and what condition is it for:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any allergies, reactions to medications, or any other medical limitations?

\_\_no \_\_yes If yes, identify and explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Do you have any of the following symptoms/conditions? Circle yes or no and describe below.

A. Do you have any history of heart disease, or heart attack? Yes / no

B. Do you have high blood pressure or any history of high blood pressure? Yes / no

C. Do you have any chest pains/pressure heart palpations, heart murmurs? Yes / no

D. Have you ever had a stroke? Yes / no

E. Do you have diabetes? Yes / no

7. If you circled “yes” to any of the above questions (letters A-E), identify the condition and describe below:

Concern:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Detailed Description:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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8. Other concerns/issues:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PHOTO/MEDIA RELEASE**

I grant Arrowhead Union High School the right to use, reproduce, assign and/or distribute photographs, films, videotapes, and sound recordings of your child for use in materials we may create.

Signature of Applicant:

Signature of Parent or Guardian: