



COLLEGE OF THE ALBEMARLE

Transform Your Tomorrow

# CONSENT FORM AND WAIVER OF LIABILITY

Participant's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Description of Activity or Activities (attach separate page if necessary)	Location:	Date:

I have been fully advised of the nature and extent of the activity described above ("the activity") and represent to you that I am physically and mentally able to participate in the activity without special accommodations or additional supervision. I wish to participate in the activity. I understand that the activity may present the risk of injury, or even death, to me, and I have been fully advised of those possibilities **I FULLY ASSUME THE RISK OF ANY SUCH INJURY OR DEATH, AND I HOLD YOU, YOUR AGENTS, EMPLOYEES, AND REPRESENTATIVES HARMLESS FROM ANY LIABILITY OR DEATH TO ME WHILE ENGAGED IN THIS ACTIVITY THAT IS CAUSED OR CONTRIBUTED TO BY MY CONDUCT OR THE CONDUCT OF ANY OTHER PARTICIPANTS. I FURTHER AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS COLLEGE OF THE ALBEMARLE ("COA") AND ANY OF ITS AGENTS, EMPLOYEES, OR REPRESENTATIVES FOR ANY INJURY OR LOSS SUFFERED BY ME DUE TO MY PARTICIPATION IN THE ACTIVITY.**

I also hold COA, its agents, employees, and representatives harmless from all liability to any other person or entity arising as a result of the conduct of myself or the other participants in the activity and I agree to defend and indemnify COA, its agents, employees, and representatives against any claim or liability arising as a result of my conduct.

If I am not able to be consulted for any reason in the case of an emergency or necessity arising during the course of the activity or as a result of the activity, I authorize you to contact the emergency contact person or persons listed above and to arrange for such medical and hospital treatment as you may deem to be advisable for my health and well-being.

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Consent \_\_\_\_\_ Date: \_\_\_\_\_

(to be used if participant is a minor or under any legal disability requiring consent of another) NOTE: By signing above, the Parent/Guardian ratifies and consents to all terms specified herein.

Special Medical Needs (if applicable)	
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