MEDICAL CONSENT FORM

Activity: _____ Location: _____

Dates: _____

[**NOTE**: For the purposes of this Agreement, the term "I" refers to both Parent/Legal Guardian and Participant.]

I, the undersigned, consent to and authorize any medical professional and others working under their supervision to treat me for any injury or illness arising from or related to my participation in the above-named Activity.

I further agree to pay any and all medical expenses, costs and other charges and to release and discharge and hold harmless the State of Hawai‘i, the University of Hawai‘i, its Board of Regents, its officers, employees, and agents from and against any liability or any claims or demands arising from or connected with such medical treatment or care.

IN CASE OF EMERGENCY:

First Person to Contact:_____ Phone: _____

Second Person to Contact: _____ Phone: _____

Physician to Contact: _____ Phone: _____

PARTICIPANT ACKNOWLEDGEMENT *(Co-signature of parent/guardian required if under 18 years of age)* _____ **Participant Signature** **Date** _____ **Print Name**	**PARENT/LEGAL GUARDIAN ACKNOWLEDGEMENT** _____ **Parent/Legal Guardian Signature** **Date** _____ **Print Name**