**INFORMED CONSENT, RELEASE OF CLAIMS**

**AND**

**MEDICAL AUTHORIZATION**

I voluntarily desire to participate in Alternative Winter Break tours and activitiesoffered at The University of Akron (University) ***from January 8, 2018-January 12, 2018***. As part of the week, I understand that I may participate in any combination of activities, including but not limited to: **tours, *workshops with professional engineers, hands-on exposure to engineering activities, panel discussions, and lunch.*** I acknowledge and understand that my participation in the above-referenced activities may expose me to certain risks and personal injuries, including death, as well as damage or destruction to my personal property. I voluntarily assume any and all risk of accident or personal injury or damage or loss to me or my person or property in connection with my participation in the above-referenced activities.

In consideration for my participation in said activities, I, myself, and for my executors, administrators, heirs and assigns, release and forever discharge The University of Akron and its Board of Trustees, its administrators, officers, instructors, agents, and employees (collectively the “University”) and tour volunteers and participants from any and all claims for loss, damage injury or cost and any action whatsoever, including but not limited to those based on negligence, that I might have myself or could be brought on my behalf, and which arise in any manner out of my participation in this activity. I understand that this Release means, among other things, that I am giving up my right to sue The University of Akron and its Board of Trustees, its administrators, officers, employees, agents and students, as well as tour participants for any such loss, damage, injury or cost that I may incur.

I hereby consent to the reasonable discretion of The University of Akron employees, students, or volunteers as well tour volunteers or participants supervising and operating the above-referenced activity and further authorize the administration or emergency first aid care and treatment for myself, the administration of any treatment deemed necessary by a licensed physician or dentist, and the transfer to any hospital, clinic or other facility reasonably accessible. I understand that should any such medical care or treatment be necessary, I am fully responsible for all costs associated with such care and treatment. I further agree to hold The University of Akron, as well as its Board of Trustees, officers, employees, agents, representatives, or volunteers harmless from any claims arising from the same.

I agree that this release binds me and my child’s heirs, administrators, executors and/or assignees.

**I UNDERSTAND THAT THIS IS A LEGAL DOCUMENT. I HAVE READ AND UNDERSTAND THIS RELEASE AND I UNDERSTAND ALL ITS TERMS. I EXECUTE IT VOLUNTARILY AND WITH FULL KNOWLEDGE OF ITS MEANING AND SIGNIFICANCE.**

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

Student’s Name (Printed) Date

**University of Akron**

**Student Emergency Information**

**PERSONAL INFORMATION:**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(LAST) (FIRST) (MI)

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(STREET)

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

(CITY) (STATE) (ZIP CODE)

CELL PHONE (\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE(\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT ID NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL INSURANCE COMPANY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSON TO CONTACT IN CASE OF AN EMERGENCY:**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(LAST) (FIRST) (RELATIONSHIP TO STUDENT)

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(STREET)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (CITY) (STATE) (ZIP CODE)

CELL PHONE (\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE(\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU HAVE ANY MEDICAL PROBLEMS THAT WE NEED TO KNOW ABOUT?**

No\_\_\_\_\_\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ IF YES, PLEASE EXPLAIN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU HAVE ANY ALLERGIES (include both Food and Drug Allergies)?**

No\_\_\_\_\_\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ IF YES, PLEASE EXPLAIN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ARE YOU TAKING ANY MEDICATION?**

No\_\_\_\_\_\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ IF YES, PLEASE EXPLAIN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_