CALIFORNIA STATE UNIVESITY MONTEREY BAY *and*
UNIVERSITY CORPORATION AT MONTEREY BAY

Please complete both sides of this form

INDIVIDUAL
WAIVER OF LIABILITY INDEMNIFICATION AND HOLD HARMLESS AGREEMENT

1. In consideration of being allowed to participate in _____course field trips/activities in _____
(SEP course prefix / number) (Semester / Year course offered)

I hereby RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE THE STATE OF CALIFORNIA, THE TRUSTEES OF THE CALIFORNIA STATE UNIVERSITY, the UNIVERSITY COR[PORATION AT MONTEREY BAY, AND THEIR OFFICERS, DIIRECTORS, AND EMPLOYEES (hereinafter collectively referred to as the "RELEASEES") from any and all liabilities, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by minor, or to any property belonging to me or minor, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES, or otherwise, while participating in such activity, or while in, on or upon the premises where the activity is being conducted.

2. I am fully aware of the risks and hazards connected with the activity, the risk of which include but are not limited to sickness, injury, loss and death, and I hereby elect to voluntarily participate in said activity, and to enter the above-named premises and engage in such activity knowing that the activity may be hazardous to participant or my property. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS OF LOSS, PROPERTY DAMAGE OR PERSONAL INJURY, INCLUDING DEATH, that may be sustained by participant, or any loss or damage to property owned by me, as a result of being engaged in such an activity, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASEES or otherwise.

3. I further hereby AGREE TO INDEMNIFY AND HOLD HARMLESS the RELEASEES from any loss, liability, damage or costs, including court cost and attorney's fees, that they may incur due to participation in said activity, WHETHER CAUSED BY NEGLIGENCE OF RELEASEES or otherwise.

4. It is my express intent that this Release, and Hold Harmless Agreement, shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a RELEASE, WAIVER, DISCHARGE, AND COVENANT NOT TO SUE the above-named RELEASEES. I hereby further agree that this waiver and Liability and Hold Harmless Agreement shall be construed in accordance with the laws of the State of California.

IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing Waiver of Liability Indemnification and Hold Harmless Agreement, understand it and sign it voluntarily as my own free act and deed; no oral representations, statements, or inducements, apart from the foregoing written agreement, have been made. As parent/guardian, I certify that he/she is in excellent health and has no physical, mental, or emotional problems that are likely to prevent participation in strenuous physical activity. I give permission for participant to be medically treated for illness occurring or injury sustained during such participation and certify that he/she is covered by medical insurance.

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MEDICAL TREATMENT CONSENT AGREEMENT

I hereby give my consent to participate in the Science & Environmental Policy Program duly approved by the California State University Monterey Bay. I further agree to relieve the Trustees of the California Sate University, the California State University Monterey Bay, the University Corporation at Monterey Bay, the State of California, and their respective employees, staff members and agents of any and all liabilities that may result from my participation in this program. The undersigned parent/guardian of the student hereby authorizes staff members of the California State University Monterey Bay and the University Corporation at Monterey Bay to act as agents for the undersigned parent/guardian and to consent to any hospital care when any or all of the foregoing is deemed advisable by any physician licensed under the Medical Practice Act or by any dentist licensed under the Dental Practice Act. This authorization is given pursuant to the California Family Code Section 6910 in advance of any specific diagnosis, treatment, medical care or dental care being required.

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By signing below, student/guardian certifies that s/he has read the Liability Indemnification and Medical Treatment Consent form in its entirety.

Student's Signature:_____ **Date:**_____

Parent's signature: _____ **Date:**_____
Signature of Parent/Legal Guardian (if under 18 years old)

Return to: Science & Environmental Policy
Chapman Science Academic Center, Rm E135
Phone: (831) 582-5187 FAX: (831) 582-4145

CALIFORNIA STATE UNIVESITY MONTEREY BAY *and*
UNIVERSITY CORPORATION AT MONTEREY BAY

Please complete both sides of this form

MEDICAL TREATMENT CONSENT INFORMATION (*Required*)

Personal Information (Please Print)

Course Prefix/Number_____ Semester/Year Course Offered:_____

Student's Last Name_____ Student's First Name:_____MI:_____ Date of Birth:_____

Phone where student can be reached:_____ Work Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Female:_____ Male:_____ Weight:_____ Height:_____

Do you know of any reason why you should be restricted in physical activity? **Yes / No**.

Are you taking any medications? **Yes / No** If yes, which medication(s)?_____

Do you have any allergies to food, bees, plants, animals, medications, or other substances? **Yes / No**.

Please describe: _____

Please note that if you have allergies that require preventative or emergency medications (inhalers, epiPENs, or other), it is your responsibility to bring these required medications with you to all class activities.

Emergency Contact #1

Name:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell/Work Phone:_____

Emergency Contact #2

Name:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell/Work Phone:_____

Insurance Information

You are responsible for any medical expenses incurred.

Are you covered by health insurance? **Yes / No**

Insurance Co. Name:_____ Policy #:_____

Name of Insured: _____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:(_____)_____ Cell/Work Phone:(___)_____

Physician Information

Name_____

Address _____ City_____ State_____ Zip _____

Phone: (_____) _____ Alternative Phone: (_____) _____

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