

Agreement for Indemnification, Release, and Consent for Emergency Treatment

I, _____ (print name), age _____, desire to participate voluntarily in the Lafayette County 4-H Shooting Sports activities at the University of Wisconsin-Madison Division of Extension - Lafayette County 4-H.

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 the University of Wisconsin-Madison Division of Extension - Lafayette County 4-H Youth Development Educator, at 608-776-4820.

Hold Harmless, Indemnity and Release:

In consideration of permission for me to voluntarily participate in Lafayette County 4-H Shooting Sports activities, today and on all future dates, I for myself, my heirs, personal representatives or assigns, agree to defend, hold harmless, indemnify and release the Board of Regents of the University of Wisconsin System, The University of Wisconsin–Madison Division Of Extension - Lafayette County 4-H, and their officers, employees, agents, and volunteers, 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 in from my participation in the above-listed program. This release includes claims based on the negligence of the Board of Regents of The University of Wisconsin System, The University of Wisconsin–Madison Division of Extension - Lafayette County 4-H 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.**

_____	_____	_____
Participant Name (print)	Participant’s Signature	Date
_____	_____	_____
Parent/Guardian Name (print) (If participant is under age 18)	Signature of Parent/Guardian (If participant is under age 18)	Date

Consent for Emergency Treatment

I authorize the University of Wisconsin-Madison Division of Extension – Lafayette County 4-H 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.**

_____	_____	_____
Participant Name (print)	Participant’s Signature	Date
_____	_____	_____
Parent/Guardian Name (print) (if participant is under age 18)	Signature of Parent/Guardian (if participant is under age 18)	Date

EMERGENCY CONTACT: Name: _____ **Phone:** _____

An AA/EEO employer, University of Wisconsin-Extension provides equal opportunities in employment and programming, including Title VI, Title IX and ADA requirements.

La Universidad de Wisconsin-Extensión, un empleador con igualdad de oportunidades y acción afirmativa (EEO/AA), proporciona igualdad de oportunidades en empleo y programas, incluyendo los requisitos del Título VI, Título IX, y de la Ley Federal para Personas con Discapacidades en los Estados Unidos (ADA).



UW-MADISON EXTENSION