HELENA COLLEGE
University of Montana

APPENDIX 2 – STUDENT AGREEMENT TO PARTICIPATE

Assumption of Risk, Indemnification, Release for College-Sponsored Travel

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I, _____ *(name)*, age _____, desire to participate voluntarily in the Helena College sponsored _____ *(description of event)* trip to _____ *(destination)* on _____ *(dates of travel)*.

Student ID: _____ Cell Phone:_____

I UNDERSTAND THAT I AM BEING ASKED TO READ THE FOLLOWING PARAGRAPHS CAREFULLY. I UNDERSTAND THAT IF I WISH TO DISCUSS ANY OF THE TERMS CONTAINED IN THIS AGREEMENT, I MAY CONTACT _____ *(name of faculty/staff leading travel)* AT _____ *(phone number of faculty/staff leading travel)*.

ASSUMPTION OF RISKS

I understand that _____ *(description of activity)*, by its very nature, may carry with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries and/or illness. I am aware of the risks of participation, which include, but are not limited to, minor injury, such as bruises, contusions, broken bones, concussion, and catastrophic injuries, such as paralysis and even death. I understand that Helena College has advised me to seek the advice of my physician before participating in the above-listed activity. I acknowledge that I have been advised to have health and accident insurance in effect and that no such coverage is provided for me by Helena College, The University of Montana, the Board of Regents of the Montana University System, or the State of Montana (collectively, the "Releasees"). **I KNOW, UNDERSTAND, AND APPRECIATE THE RISKS THAT ARE INHERENT IN THE ABOVE-LISTED ACTIVITY. I HEREBY ASSERT THAT MY PARTICIPATION IS VOLUNTARY AND THAT I KNOWINGLY ASSUME ALL SUCH RISKS.**

Signature: _____ **Date:** _____

Signature of Parent or Guardian: _____ **Date:** _____
(If Participant is under 18)

EMERGENCY CONTACT INFORMATION

Name: _____ **Relationship:** _____

Phone Number: _____ **Alternate Number:** _____

CONSENT FOR EMERGENCY TREATMENT: I authorize Helena College, University of Montana 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.

Signature: _____ **Date:** _____

Signature of Parent or Guardian: _____ **Date:** _____
(If Participant is under 18)