UNIVERSITY OF HAWAI‘I AT MĀNOA
Native Hawaiian Student Services (NHSS)
Outreach Program Visitor Form – For Adult Participants ONLY

Name of Participant: ____________________________________________
(Last Name, First Name, Middle Initial)

Title of Outreach Event: Mālama Program
Date(s): ______________________________________

ASSUMPTION OF RISK AND RELEASE

I, the undersigned, certify that I am in good physical health and able to participate in all activities of the above named program.

I also understand and acknowledge that there are inherent dangers and risks involved with participation in the above named program with the University of Hawai‘i.

I understand that I should be covered during the Dates of Program above by a private medical and liability policy; and I further understand that the University of Hawai‘i does not provide such insurance or otherwise indemnify individuals with respect to injuries or other liabilities arising out of participation in the above named program.

Therefore, in consideration of my being permitted to participate in the above named program, I/We hereby agree to assume all risks and responsibilities surrounding his/her participation in the above named program.

I have read and understand any and all written materials setting forth the requirements for participation in the above referenced activity, as well as those explained by the Native Hawaiian Student Services staff, and I agree to strictly observe them. Further, I, do for myself, my heirs, executors, and administrators hereby accept full responsibility for my participation and agree to indemnify, release and discharge the University of Hawai‘i, State of Hawai‘i, its officers, employees, agents, and assigns from any and all claims or actions for property damage, personal injury, and/or death arising from such participation in the above named program or growing out of or caused by any acts or omissions during my participation in above named program.

Signature* ___________________________ Date ___________________________
* Separate form REQUIRED if the participant is UNDER 18 years old, please contact NHSS@hawaii.edu.

Print Name of Participant

Please provide your initials if you agree with the following statements.
* Separate form REQUIRED if participant is UNDER 18 years old.

I certify that I am at least 18 years of age and I voluntarily agree to participate. *** INITIAL HERE : _____ ***

I give permission to NHSS to use photographs and/or video of my participation in program activities for educational and promotional uses. I have the right to withdraw my consent at any time. *** INITIAL HERE : _____ ***

MEDICAL CONSENT FORM

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 program.

I further agree to pay any and all medical expenses, costs and other charges and to release and discharge and hold harmless the University of Hawai‘i, State of Hawai‘i, its officers, employees, agents, and assigns 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: ______________________

Signature ___________________________ Date ___________________________

Print Name

NHSS Outreach Volunteer Waiver – Rev. October 26, 2011