UNIVERSITY OF HAWAIʻI AT MĀNOA

Ka Papa Loʻi ʻO Kānewai

Hawaiʻinuiākea School of Hawaiian Knowledge

Name of Adult Participant: _____

Last Name *First Name* *Middle Initial*

Program: _____ **Date(s) of Program:** _____

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 and Ho'okahe Wai Ho'oulu 'Āina, which include, but are not limited to: infections from stream water and plants, and/or injuries that could be caused from falling fruits or slippage on the uneven grounds surrounding the patches and 'auwai.

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 and Ho'okahe Wai 'oulu 'Āina 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 hereby agree to assume all risks and responsibilities surrounding my 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 b)' the instructor(s), 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, Ho'okahe Wai Ho'oulu 'Āina, 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 of Adult Participant *Date*

_____

Print Name

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, Ho'okahe Wai Ho'oulu 'Āina, 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 of Adult Participant *Date*

_____

Print Name