



Participant Release Form

Program Name: _____ **Program Dates:** _____

Indiana University, through its Bradford Woods programs (hereinafter referred to as University), manages and conducts adventure and outdoor based programs. These activities are supervised by University staff, interns, and school personnel. Although novice skills will be taught and supervised by competent and experienced adult leaders, there is some degree of risk involved in the various activities and the ultimate safety of each participant will depend on the participants' willingness to listen and to abide by the instructions, rules, and regulations given throughout the program.

The safety and well-being of each participant is of paramount importance to Bradford Woods and the professional staff, employees, and trustees of Indiana University. All reasonable care and precautions are taken to ensure a fun educational experience. The following "acknowledgment, assumption of risk and release of claims" is both a requirement of insurance coverage and an important reminder to you as a parent / guardian or participant to be sure that you or your child is properly prepared.

Acknowledgement, Assumption of Risk, and Release of Claims

_____ desires to participate in the program specified above. I understand the program offered through Bradford Woods may include, but is not limited to, the following potential hazardous activities: ground based initiatives, individual and group challenge activities, low, intermediate, and high ropes courses, hiking, camping, backpacking, caving, canoeing, other water based activities, fishing, archery, arts and crafts, environmental nature studies, transportation to and from activity sites and all other activities. The inherent risks of these activities include the following: personal injury, property damage, illness, or death. I understand that Bradford Woods does not require that I participate in the above-mentioned program.

In recognition of the potentially hazardous nature of the elective program, I hereby release and fully discharge The Trustees of Indiana University, including its officers, agents, and employees, and Bradford Woods, from any and all claims or causes of action that may be brought by me, my child, or by any other person (including, but not limited to, my estate, family, successors, heirs, representatives, administrators, and/or assigns), including all liability for damage to personal property, personal injury or loss arising out of or related to my or my child's participation in the program, whether caused by IU or Bradford Woods' negligence or otherwise, to the fullest extent permitted by law. I further agree to hold harmless and indemnify The Trustees of Indiana University, Bradford Woods and their agents for all defense costs, including attorney fees, and any other costs resulting in connection with my participation in this program.

I understand that this release also relates to all claims and liability resulting during or after the program arising from a pre-existing medical condition. I have read and completed the medical history form provided by Bradford Woods and accept full responsibility for omissions or errors on the medical history form. I further understand that this release relates to all claims and liability resulting from unforeseen or intemperate weather. I have read the clothing list provided by Bradford Woods and accept full responsibility for inadequate clothing provided by me or those items which I fail to provide.

I have read this entire "acknowledgement and assumption of risk and release of claims" and fully understand the contents. My signature indicates that I have satisfied my questions and concerns regarding the above-mentioned program by talking with a representative of Bradford Woods and that I agree to the above terms.

Participant signature (Legal guardian's signature if participant is under the age of 18)

Date

Medical Services Permission Release

During participation in a Bradford Woods program, the Trustees of Indiana University, its agents, servants, and employees are hereby authorized to provide and secure any medical services, and authorize the diagnosis and treatment (including, but not limited to, surgery and the administering of anesthesia) of any injury or illness as in its judgment is necessary or advisable for me or my child.

I hereby agree that the MEDICAL HISTORY provided is true to my knowledge. I declare that I have read and understand the contents of the MEDICAL SERVICES PERMISSION and I am signing this as my free and voluntary act, irrevocably binding myself and my heirs.

Participant signature
(Legal guardian's signature if participant is under the age of 18)

Date

Photo Release

I hereby grant the University permission to take photographs, video recordings, and/or sound recordings of myself or my child. I grant the University permission to use the negatives, prints, motion pictures, video tapings, or any other reproduction of the same for educational and promotional purposes in manuals, on flyers, on the internet, or in any other manner deemed necessary. I declare that I have read and understand the contents of this PHOTOGRAPHIC RELEASE, and I am signing this as my free and voluntary act, irrevocably binding myself and my heirs.

Participant signature
(Legal guardian's signature if participant is under the age of 18)

Date

Bradford Woods Medical Form

Please fill out this form thoroughly. We will use the information provided to plan a safe and enjoyable experience. This also serves as a helpful reminder to you of physical precautions and care you may need to take because of previous injuries and other physical conditions. Any information disclosed on this form will remain confidential.

Participant Name: _____ Male Female DOB: _____

Address _____

City _____ State _____ Zip _____ Phone _____

In case of emergency, notify (name): _____ Relationship to participant: _____

Address _____

City _____ State _____ Zip _____ Phone _____

Name of Physician: _____ Phone _____

Physician's Address _____

Insurance Company _____ Policy Number _____

Medical Information: Blood Type (if known): _____ Height: _____ Weight: _____

Allergies (describe reaction): _____

Specific Dietary Needs: _____

Current medications (name, dosage, reason for taking): _____

Please list any special conditions you are aware of or have been told by a physician that we should be aware of (i.e. injuries, medical diagnosis, past surgeries, arthritis, asthma, heart disease, high blood pressure, pregnancy, etc.)
