

**IOWA STATE UNIVERSITY**  
**RELEASE AND WAIVER OF LIABILITY**

**PLEASE READ THIS CAREFULLY.**

It affects any rights you may have if you are injured or otherwise suffer damages while participating in the **Disc Golf Club (CDGC)** at Iowa State University for the school year **2009-2010**.

I, \_\_\_\_\_ (participant) hereby release, waive, discharge and covenant not to sue the **Disc Golf Club (CDGC)**, Recreation Services, the State of Iowa, the Board of Regents of the State of Iowa, Iowa State University, and any of the officers, servants, agents and employees of the above-mentioned entities (hereinafter referred to as RELEASEES) for any liability, claim and/or cause of action arising out of or related to any loss, damage or injury, including death, that occurs as a result of my participation in the above-described activities.

I agree to indemnify and hold harmless the RELEASEES whether injury is caused by my negligence, the negligence of the RELEASEES or the negligence of any third party. I further agree that this Release and Waiver of Liability shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representatives, if I am deceased, and shall be deemed as a RELEASE, WAIVER, DISCHARGE AND COVENANT NOT TO SUE the above-named RELEASEES. I hereby further agree that this Release and Waiver of Liability shall be construed in accordance with the laws of the State of Iowa.

I understand that personally owned automobiles used in conjunction with the activities of the **Disc Golf Club (CDGC)** are not covered by the university for property damage or liability. I understand that I am required to carry auto liability insurance as required by the State of Iowa.

By signing this Release and Waiver of Liability, I state that I have read and understand the conditions set forth in this Release and that I agree to all conditions set forth herein, and that I sign this voluntarily.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
ISUCard Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Parent or Guardian (if under 18)

**Medical Information-Emergency Release 2009-10**

Participant's Name \_\_\_\_\_  
Permanent Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_

**Club Name Disc Golf Club (CDGC)**

ISU Card # \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_  
Home Phone \_\_\_\_\_

**MEDICAL EMERGENCY CONTACT INFORMATION**

Person to Contact First

Name \_\_\_\_\_  
Relation to Participant \_\_\_\_\_  
Daytime Phone \_\_\_\_\_  
Evening Phone \_\_\_\_\_  
Name of Family Doctor \_\_\_\_\_  
Name of Dentist \_\_\_\_\_

Backup Contact (Relative or Friend)

Name \_\_\_\_\_  
Relation to Participant \_\_\_\_\_  
Daytime Phone \_\_\_\_\_  
Evening Phone \_\_\_\_\_  
Office Number \_\_\_\_\_  
Office Number \_\_\_\_\_

**INSURANCE POLICY INFORMATION**

The above-named participant is covered by health insurance.  Yes\*\*  No\*

\* If no, initial this line stating that you do not have health insurance and are aware that ISU and the ISU Club named above does **not** carry any health insurance for you. \_\_\_\_\_

\*\* If yes, provide the following information which is required by Iowa State University to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name \_\_\_\_\_ P.H.'s Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Relation to Participant \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Occupation \_\_\_\_\_  
P.H.'s Employer's Name/Address \_\_\_\_\_

Insurance Company Name \_\_\_\_\_  
Policy # \_\_\_\_\_ Plan # \_\_\_\_\_

**Health Information (Please Print)**

Do you have any of the following conditions or a history of any of the following conditions? (**Check all that apply.**)

- Asthma
- Diabetes
- Convulsions/seizure
- Migraine headaches
- Other condition(s): (Please list) \_\_\_\_\_
- Bronchitis
- Ear Infections
- Hay Fever
- Fainting Spells
- Heart or cardio-vascular problems/disease
- Chronic bone, muscle or joint injuries

Allergies or reactions: (**Check all that apply.**)

- Aspirin
- Penicillin
- Other (list) \_\_\_\_\_

Date of last tetanus shot (*approximate if necessary*): \_\_\_\_\_

Are you currently on any prescribed or over-the counter medication? (If so, please record the condition/ailment, name of medication, dosage, time(s) of day, prescribing physician.) \_\_\_\_\_

**TO BE READ AND SIGNED BY PARTICIPANT**

**MEDICAL EMERGENCY PERMISSION\***

The health history is correct and complete to my knowledge. If an injury or other medical condition occurs or arises, I hereby give permission to the ISU Club coordinator or volunteers to provide routine health care and seek emergency treatment including x-rays or routine tests. I agree to the release of any record necessary for treatment, referral, billing or insurance purposes. I understand that I am financially responsible for charges and hereby guarantee full payment to the attending physicians or health care unit. In the event of an emergency where I cannot decide for myself, I give permission to the physician/hospital selected by the ISU Club coordinators or volunteer to secure and administer treatment for me, including hospitalization. (\*If you cannot sign this section of the form for any reason, contact the ISU Risk Management regarding a legal waiver in order to attend and participate.)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Parent or Guardian (if under 18)

