UNIVERSITY OF ARKANSAS
DIVISION OF AGRICULTURE
Cooperative Extension Service

ExCEL Release and Waiver of Liability

FY4-H-107
3/17/04

Name _____ Age _____ Work Phone _____

Address: Street _____ City _____ Zip _____

In case of Emergency contact: _____

Relationship _____ Home Phone # _____ Work Phone # _____

STATEMENT OF UNDERSTANDING/MEDICAL INFORMATION

I am aware in signing this statement for participation in the programs at the Arkansas 4-H Center that certain activities are physically demanding. Therefore, physical fitness will increase your enjoyment and ability for participation in the activity. If for any reason you question your ability to participate in the activity, please consult with the instructors prior to participation. While it is impossible to foresee all possible dangers, some of the specific hazards which you might encounter while using the High Ropes Course and Initiatives Course include: Slipping or falling on the trail, bumps, bruises, cuts, insect bites, poison ivy, sprains, fractures or other injuries. Please note that most activities are conducted in the out-of-doors in all kinds of weather so proper dress (rain gear, warm clothing) are essential to avoid exposure to the elements. The instructors of the course will take every reasonable precaution to minimize exposure to known risks, however, as a participant you acknowledge the nature of the activity and the fact that not all of the stresses and hazards connected with the activity can be foreseen. You have the personal responsibility to follow the established safety rules and procedures to the extent that you participate in such activities. If at any time you have questions about the activity, you have the responsibility to consult with your instructor. Sponsoring agencies have the responsibility of providing a progression of appropriate activities which lead to the experiences at the ExCEL Challenge Program at the Arkansas 4-H Center.

I recognize that there is a significant element of risk in any adventure, sport or activity associated with the outdoors. Knowing the inherent risks, dangers and rigors involved in the activities, I certify that my family and I, including any minor children, are fully capable of participating in the activities.

I assume full responsibility for my family and myself, including any minor children, for bodily injury, death, loss of personal property and expense thereof, as a result of my family member(s) participating in the ExCEL Challenge Program.

EMERGENCY MEDICAL INFORMATION

Please Check Yes or No

Yes	No	
☐	☐	Allergies to foods, drugs, insect bites, dust. Please identify them and your reaction.
☐	☐	Physical disabilities or conditions which might limit your participation. Please identify them.
☐	☐	If you are presently taking medication, please identify the medication.

MEDICAL AUTHORIZATION

Parent or legal guardian must sign for all persons under 18 years of age.

I understand that health services will be available and that adult supervision will be provided. If an illness or injury develops, medical and/or hospital care will be provided and I will be notified as soon as possible. I will not hold liable the University of Arkansas, the Arkansas 4-H Foundation, the Arkansas Cooperative Extension Service, or its employees for any injury or damage received by my child while he/she is being transported or is engaged in this activity.

I understand and accept the above statement and further authorize each of the following:

A. The health history on the front is correct and the participant has my permission to engage in all program activities.
B. I grant permission to the attending physician and/or the attendant health service staff to employ such diagnostic procedures and medical treatment as deemed necessary.
C. I authorize medical care units to release medical record information to the health insurance carrier for the 4-H events and/or the Cooperative Extension Service in or to process claims.
D. I understand that I am financially responsible for charges and hereby guarantee full payment to the attending physicians and/or health care units.

Signature _____ Date _____

(If 18 or under, parent or Guardian must sign.)