AGREEMENT FOR INDEMNIFICATION, RELEASE, AND CONSENT FOR EMERGENCY TREATMENT

I, (print name) ____, age ________, desire to participate voluntarily in the Green Lake County 4-H Shooting Sports activities at the University of Wisconsin – UW-EXTENSION Green Lake County 4-H.

I UNDERSTAND THAT I AM BEING ASKED TO READ EACH OF THE FOLLOWING PARAGRAPHS CAREFULLY. I UNDERSTAND THAT IF I WISH TO DISCUSS ANY OF THE TERMS CONTAINED IN THIS AGREEMENT, I MAY CONTACT the Green Lake County UW-Extension 4-H Youth Development Educator, AT TELEPHONE NUMBER 920-294-4032.

HOLD HARMLESS, INDEMNITY AND RELEASE

In consideration of permission for me to voluntarily participate in Green Lake County 4-H Shooting Sports activities, today and on all future dates, I, for myself, my heirs, personal representatives or assigns, agree to defend, hold harmless, indemnify and release the Board of Regents of the University of Wisconsin System, the University of Wisconsin - Extension, Green Lake County 4-H, and their officers, employees, agents, and volunteers, from and against any and all claims, demands, actions, or causes of action of any sort on account of damage to personal property, or personal injury, or death which may result from my participation in the above-listed program. This release includes claims based on the negligence of the Board of Regents of the University of Wisconsin System, the University of Wisconsin, UW-Extension, Green Lake County 4-H, and their officers, employees, agents, and volunteers, but expressly does not include claims based on their intentional misconduct or gross negligence. I UNDERSTAND THAT BY AGREEING TO THIS CLAUSE I AM RELEASING CLAIMS AND GIVING UP SUBSTANTIAL RIGHTS, INCLUDING MY RIGHT TO SUE.

Signature: ____ Date: __________________

Signature of Parent or Guardian: __________________________ Date: __________________
(if Participant is Under 18)

CONSENT FOR EMERGENCY TREATMENT

I authorize the University of Wisconsin – UW-EXTENSION Green Lake Co. 4-H and its designated representatives to consent, on my behalf, to any emergency medical/hospital care or treatment to be rendered upon the advice of any licensed physician. I AGREE TO BE RESPONSIBLE FOR ALL NECESSARY CHARGES INCURRED BY ANY HOSPITALIZATION OR TREATMENT RENDERED PURSUANT TO THIS AUTHORIZATION.

Signature: ____ Date: __________________

Signature of Parent or Guardian: __________________________ Date: __________________
(if Participant is Under 18)