



# WAIVER, INDEMNIFICATION, AND MEDICAL TREATMENT AUTHORIZATION FORM

1. EXCULPATORY CLAUSE. In consideration for receiving permission to participate in any and all activities of Summer Recreational Sports Camp (herein referred to as "activity"), which is sponsored by Recreational Sports (herein referred to as "sponsor"), a member of The Texas A&M University System, I hereby release, waive, discharge, covenant not to sue, and agree to hold harmless for any and all purposes sponsor, The Texas A&M University System, the Board of Regents for The Texas A&M University System, and their members, officers, servants, agents, volunteers, or employees (herein referred to as RELEASEES or INDEMNITEES) from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while participating in such activity, while traveling to and from the activity, or while on the premises owned or leased by RELEASEES, **including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of RELEASEES.** I understand this waiver does not apply to injuries caused by intentional or grossly negligent conduct.
2. INDEMNITY CLAUSE. I am fully aware that there are inherent risks to myself and others involved with this activity, including but not limited to injury or death, and I choose to voluntarily participate in said activity with full knowledge that the activity may be hazardous to me and my property, and to the person and property of others. I acknowledge there may be physically strenuous activities. I know of no medical reason why I should not participate. **I agree to indemnify and hold harmless INDEMNITEES** from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, which may occur to myself, other participants, and third-persons as a result of my participation in said activity, **including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of INDEMNITEES.**
3. NO INSURANCE. I understand that RELEASEES do not maintain any insurance policy covering any circumstance arising from my participation in this activity or any event related to that participation. As such, I am aware that I should review my personal insurance coverage. Sponsor does not carry general liability insurance to cover claims arising from this activity so it seeks a waiver of claims as additional consideration for the right to participate so sponsor, a governmental unit of the State of Texas, can (a) provide the activity at the lowest possible cost to participants; and (b) provide access to a greater number of participants by expending limited resources on program materials rather than on liability insurance.
4. BINDS HEIRS. It is my express intent that this agreement 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 governed by the laws of the State of Texas.
5. MEDICAL AUTHORIZATION, INDEMNITY FOR MEDICAL EXPENSES, and WAIVER. I understand RELEASEES cannot be expected to control all of the risks articulated in this form and RELEASEES may need to respond to accidents and potential emergency situations. Therefore, I hereby give my consent for any medical treatment that may be required, as determined by a medical professional at the medical facility, during my participation in this activity with the understanding that the cost of any such treatment will be my responsibility. I agree to indemnify and hold harmless INDEMNITEES for any costs incurred to treat me, even if an INDEMNITEE has signed hospital documentation promising to pay for the treatment due to my inability to sign the documentation. I further agree to release, waive, discharge, covenant not to sue, and agree to hold harmless for any and all purposes, RELEASEES from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while receiving medical care or in deciding to seek medical care, including while traveling to and from a medical care facility, **including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of RELEASEES.** I understand this waiver does not apply to injuries caused by intentional or grossly negligent conduct.

6. VOLUNTARY SIGNATURE. In signing this agreement I acknowledge and represent that I have read it, understand it, and sign it voluntarily as my own free act and deed; sponsor has not made and I have not relied on any oral representations, statements, or inducements apart from the terms contained in this agreement. I execute this document for full, adequate and complete consideration fully intending to be bound by the same, now and in the future. **For students engaging in extracurricular activities:** I understand I can choose not to sign this document and free myself from its terms and the associated risks of the activity by simply not participating in the activity and choosing some other activity available to me that has a lower level of risk to me. I further understand this is a voluntary, extracurricular activity; therefore it is not required for me to obtain college credits and not participating in this activity will in no way hinder my ability to obtain a degree from the university. **For students going on fieldtrips or other class-related activities:** I understand participation in this class/fieldtrip/activity is not mandatory and I will not be penalized for failing to participate in this activity because an alternative activity exists for which I can receive like credit. While I understand alternative activities are available to me that do not have the risks associated with this activity I still desire to voluntarily engage in this activity.

**SIGNING THIS DOCUMENT INVOLVES THE WAIVER OF VALUABLE LEGAL RIGHTS. CONSULT YOUR ATTORNEY BEFORE SIGNING THIS DOCUMENT.**

**SIGNED** this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

**Participant's Signature:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Participant's Date of Birth:** \_\_\_\_\_

**Parent or Legal Guardian's Signature** (if Participant is under 18 years old): \_\_\_\_\_

**Parent or Legal Guardian's Printed Name** (if Participant is under 18 years old): \_\_\_\_\_

**INSTRUCTIONS:**

- (1) The document should be printed in a font size no smaller than 10-point type. This is 10-point type. This is 12-point type.
- (2) The formatting/font style (***bolded, underlined, and italicized***) in paragraph nos. 1, 2, 5 & 6 should not be altered.

*HR revised and OGC approved 4/29/10*

Texas A&M International University  
Student Health Services  
Health History Form

**PERSONAL INFORMATION**

Name: \_\_\_\_\_ Sex: M F Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ SS#: \_\_\_\_\_  
Street/P.O.Box City, State, Zip

**EMERGENCY CONTACT INFORMATION**

*Primary Contact:*

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone Number: \_\_\_\_\_

*Secondary Contact:*

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**DRUG AND/OR OTHER ALLERGIES**  
(List those your child is allergic to and type of reaction)

\_\_\_\_\_  
\_\_\_\_\_

**CHRONIC MEDICAL OR EMOTIONAL CONDITIONS**

\_\_\_\_\_  
\_\_\_\_\_

**MEDICINES YOUR CHILD IS TAKING**  
(List medications your child is taking with or without prescription)

\_\_\_\_\_  
\_\_\_\_\_

**REASONS FOR LAST HOSPITALIZATIONS**

\_\_\_\_\_ Approx. Year: \_\_\_\_\_  
\_\_\_\_\_ Approx. Year: \_\_\_\_\_

**PERSONAL HEALTH HISTORY**

*Females Only:*

Onset of menstrual cycle: at age \_\_\_\_\_ Duration of cycle (days): \_\_\_\_\_

Check one (regarding menstrual cycle) PAIN ( ) None ( ) Mild ( ) Heavy ( ) Severe

**FAMILY MEDICAL HISTORY**

Has a relative (mother/father/brother/sister/grandparent) suffered from any of the following:

*Check all that apply.*

DESCRIPTION	Yes	No	RELATIONSHIP
Abn. Bleeding Tendency	[ ]	[ ]	_____
Hay Fever	[ ]	[ ]	_____
Anxiety	[ ]	[ ]	_____
Eating Disorder	[ ]	[ ]	_____
Obesity	[ ]	[ ]	_____
Depression	[ ]	[ ]	_____
Cancer	[ ]	[ ]	_____
Diabetes	[ ]	[ ]	_____
Epilepsy/Seizures	[ ]	[ ]	_____
Heart Disease	[ ]	[ ]	_____
High Blood pressure	[ ]	[ ]	_____
High Cholesterol	[ ]	[ ]	_____
History of Stroke at an early age (< 50 yrs.)	[ ]	[ ]	_____
Tuberculosis	[ ]	[ ]	_____
Asthma	[ ]	[ ]	_____
Kidney Disease	[ ]	[ ]	_____
Other:			_____

**HAS THE CHILD EVER BEEN TREATED BY A PHYSICIAN FOR ANY OF THE FOLLOWING**

<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Dizziness/fainting spells	<input type="checkbox"/> Nervous Breakdown
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Allergies to food/pollen	<input type="checkbox"/> Eczema, hives, rashes	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy/seizures/convulsions	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eye problems	<input type="checkbox"/> Rubella, German Measles
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gall Bladder Disease	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Hyperactivity Disorder	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Broken Bone	<input type="checkbox"/> Headaches	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Cancer, tumor	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Chronic Back problems	<input type="checkbox"/> Hernia	<input type="checkbox"/> Ulcer in stomach
<input type="checkbox"/> Chronic cough	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chronic skin problems	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Colitis/colon problems	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Weight-recent gain or loss
<input type="checkbox"/> Congenital heart disease	<input type="checkbox"/> Liver Disease, Hepatitis, Yellow Jaundice	<input type="checkbox"/> Worry/Anxiety
<input type="checkbox"/> Depression	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Other diseases:
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Menstrual Problems	_____
<input type="checkbox"/> Diminished hearing	<input type="checkbox"/> Mumps, Measles, Chickenpox	_____

**PLEASE PROVIDE ADDITIONAL INFORMATION ON ANY ITEMS CHECKED ABOVE**

\_\_\_\_\_

\_\_\_\_\_

**AUTHORIZATION OF TREATMENT**

I hereby certify that the above history is complete to the best of my knowledge and I do hereby give permission for TAMIU Student Health Services provider(s) doctors, nurse practitioner, and nurses to perform examinations, diagnostic testing, and other procedures necessary to help maintain my child's health for as long as he/she is attending Texas A&M International University and/or all summer programs. I understand and give consent for protected health information to be used to carry out treatment or for other health care operator.

\_\_\_\_\_  
Print parent/legal guardian name

\_\_\_\_\_  
Signature of parent/legal guardian

\_\_\_\_\_  
Date



# Texas A&M International University

## MODEL RELEASE FOR MINORS

In consideration of my engagement as a model, and for other good and valuable consideration herein acknowledged as received, I hereby grant to Texas A&M International University and those acting with the University's authority and permission, the irrevocable and unrestricted right and permission to copyright, in TAMIU's own name or otherwise, and use, re-use, publish, and re-publish photographic or electronic portraits or pictures of me or in which I may be included, in whole or in part, or composite or distorted in character or form, without restriction as to changes or alterations, in conjunction with my own or a fictitious name, or reproductions, thereof in color or otherwise, made through any medium at University studios or elsewhere, and in any and all media now or hereafter known for illustration, promotion, art advertising trade, or any other purpose whatsoever. I also consent to the use of any printed or electronic matter in conjunction therewith.

I hereby waive any right that I may have to inspect or approve the finished product or products and the advertising copy or other matter that may be used in connection therewith or the use to which it may be applied.

I hereby release, discharge and agree to save harmless Texas A&M International University (TAMIU), the University's legal representatives and assigns, and all persons acting under University permission or authority or those for whom they are acting, from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said picture or in any subsequent processing thereof, as well as any publications, thereof, including without limitation any claims for libel or invasion of privacy.

I hereby certify that I am the parent and/or guardian of \_\_\_\_\_, a minor under the age of 18 years, and I hereby consent that any photographs which have been, or are about to be taken by Texas A&M International University, may be used by the University for the purpose set forth in the above authorization, signed by the minor model, with the same force and effect as if executed by me. I have read the authorization, release, and agreement, prior to its execution and I am fully familiar with the contents thereof. This release shall be binding upon me and my heirs, legal representatives, and assigns.

### MODEL

Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PARENT AND/OR GUARDIAN

Name (Print): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### WITNESS

Name (Print): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_