

CALIFORNIA STATE UNIVERSITY MONTEREY BAY
ADULT SAILING / KAYAKING
AGREEMENT AND RELEASE OF LIABILITY

Please review, complete and sign each of the forms/waivers. Each participant, parent or guardian must sign. No student will be allowed to participate without this form. You may fax form to: 831.582.4023 (bring original to class).

Participant's Name: (please print) _____ Phone: _____

Address: _____ Class name/date _____

I am aware that participation in sailing and or kayaking lessons MAY INVOLVE RISKS OF INJURY, including, but not limited to *blisters, sprains, strains, bruises, collisions with other students, and possible drowning* and I FREELY UNDERSTAND THE RISKS of participating in the Sailing/Kayaking program sponsored by the Foundation of California State University, Monterey Bay. I am capable of swimming.

As lawful considerations for being permitted to enroll in the Foundation of CSUMB Sailing/Kayaking program, I AGREE TO RELEASE FROM ANY LEGAL LIABILITY AND AGREE NOT TO SUE The Foundation of California State University, Monterey Bay, California State University, Monterey Bay, the Trustees of the California State University, The State of California or their officers, agents or employees for any and all injuries caused by or resulting from any participation in the sailing/kayaking program whether or not such injury or death was caused by alleged negligence.

I AM AWARE THAT THIS CONTRACT IS LEGALLY BINDING AND THAT I AM RELEASING LEGAL RIGHTS BY SIGNING IT.

I HAVE READ THIS RELEASE AND BY SIGNING BELOW I AGREE TO ALL OF ITS PROVISIONS.

MEDICAL TREATMENT CONSENT FORM

I authorize the Instructor in charge of the Sailing / Kayaking program to make decisions regarding my emergency care or treatment including seeking and approving medical treatment. This Emergency Authorization is valid only for the dates of enrollment in the Sailing/Kayaking program.

I hereby authorize staff members of the Foundation of California State University, Monterey Bay and or California State University, Monterey Bay to act as agents for the undersigned and to consent to any diagnostic procedure (including x-rays), to the administration of any medical care, dental care or surgical treatment, or to any hospital care when any or all of the foregoing is deemed advisable by any physician licensed under the Medical Practice Act or by any dentist licensed under the Dental Practice Act. This authorization is given pursuant to California Family Code Section 6910 in advance of any specific diagnosis, treatment, medical care or dental care being required.

Participant's Signature: _____ Date: _____

Emergency Telephone: _____ Birth Date: _____

Alternate name and number to call in an emergency: _____

The following additional information is requested as it will be helpful in providing treatment, if necessary:

1. Are you taking any medication(s)? Yes No
If yes, which medication(s)? _____
2. Are you allergic to any medication(s)? Yes No
If yes, which medication(s)? _____
3. Do you have any special dental problem(s)? Yes No
If yes, specify: _____
4. Do you wear contact lenses? Yes No
5. Do you have medical insurance? Yes No
If yes, please list name of the policy holder _____ Group # _____
6. Do you have other dental insurance? Yes No
If yes, please list name of the policy holder _____ Group # _____
7. Name of your Doctor: _____ Phone # _____