

STUDENT ORGANIZATION WAIVER, INDEMNIFICATION, AND MEDICAL  
TREATMENT AUTHORIZATION FORM

1. EXCULPATORY CLAUSE. In consideration for receiving permission to participate in any and all activities of \_\_\_\_\_ (herein referred to as “activity”), which is sponsored by \_\_\_\_\_, a Recognized Student Organization, (herein referred to as “organization”), I hereby release, waive discharge, covenant not to sue, and agree to hold harmless for any and all purposes organization, The Texas A&M University System, the Board of Regents for the Texas A&M University System, Texas A&M University, and their members, officers, servants, agents, volunteers, or employees (herein referred to as (RELEASEES or INDEMNITIES) 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 RLEASEES, **including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of RELLEASEES.** 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 \_\_\_\_\_

\_\_\_\_\_ 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 INDEMNITIES 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 INDEMNITIES.**

3. NO INSURANCE. I understand that RELEASEES may or may not maintain any insurance policy covering any circumstances 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. Organization may 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 organization, 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 the problem 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 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 declining to seek medical care, including when traveling to and from a medical care facility, **including injuries sustained as a result of the sole, joint or concurrent 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: organization 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. I understand I can choose not to sign this document and free myself from other its terms and associated risks of the activity by simply not participating in the activity and choosing some other activity other available to me that has a lower-level 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. While I understand the 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 Name: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Participant's Date of Birth: \_\_\_\_\_

Parent of Legal Guardian Signature: \_\_\_\_\_

Parent of Legal Guardian Printed Name: \_\_\_\_\_

This document should remain on file for two years after date of event

Emergency Contact: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Health Insurance Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Auto Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Please list any special services you may require due to an existing medical condition or physical disability.

\_\_\_\_\_