



ASSUMPTION OF RISK AND RELEASE FROM LIABILITY ("Release")

I am signing this Release so that I can participate in the Learning Experience described below:

\_\_\_\_\_ is arranging a Learning Experience to \_\_\_\_\_ in  
Department Name Learning Experience Name or Location

\_\_\_\_\_, for the purpose of: \_\_\_\_\_ on \_\_\_\_\_  
City, State, Province, Country Reason for Learning Experience Date

I understand that my participation in this Learning Experience is voluntary.

I understand that there are certain risks inherent in such Learning Experience, including any associated travel, meals and lodging. These risks may include but are not limited to accidents; exposure to adverse weather conditions; theft, loss, or damage of personal property; physical, mental and emotional injuries; and catastrophic death.

I confirm that I have resolved concerns, if any, about my health or ability to participate in or observe the Learning Experience with my physician before deciding to participate.

I agree to assume the risk that unexpected events may occur and result in harm, injury, illness or death to me or damage to my personal property or effects while I am participating in or observing the Learning Experience or while I am traveling to or from the Learning Experience. I further agree to release and hold Indiana Wesleyan University, its Board of Trustees, and any of its employees harmless from any and all liability which could result from this Learning Experience.

If I require emergency medical treatment, please contact:

Name of Emergency Contact Person \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

If the Emergency Contact Person I have listed is not available, please contact:

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

I also agree that any medical expenses that I might incur due to my involvement in this Learning Experience will be my responsibility.

I consent to the provision of emergency medical treatment to the extent that the treatment is necessary in the medical opinion of the licensed doctor rendering the treatment.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Participant Name \_\_\_\_\_  
(please print)