MEDICAL CONSENT FORM

[NOTE: For the purposes of this Agreement, the term “I” refers to both Parent/Legal Guardian and Student.]

I, the undersigned, consent to and authorize any medical professional and others working under their supervision to treat me for any injury or illness arising from or related to my participation in _____ Ka Hikina O Ka La Program Activities _____ on ___ AY 2015 - 2016.

I further agree to pay any and all medical expenses, costs and other charges and to release and discharge and hold harmless the Research Corporation of the University of Hawai‘i, the University of Hawai‘i, its officers, employees, agents, and assigns from and against any liability or any claims or demands arising from or connected with such medical treatment or care.

IN CASE OF EMERGENCY:

First Person to Contact: ___________________________ Phone: _____________

Second Person to Contact: ___________________________ Phone: _____________

Physician to Contact: ___________________________ Phone: _____________

Signature of Student ___________________________ Date ___________________________

Print Name __________________________________________________________________

Signature of Parent/Legal Guardian ___________________________ Date ___________________________

Print Name __________________________________________________________________

(required if the Student is under the age of 18 years)