JAMES MADISON UNIVERSITY
RISK ASSESSMENT AND RELEASE FORM

Student’s name (First & Last): Please Print ______________________________________

The purpose of this form is to inform you of certain risks and responsibilities that you will be assuming as a participant in the Valley Scholars Programs (VSP).

I. ADMINISTRATIVE INSTRUCTIONS AND INFORMATION

a. The Valley Scholars Program has provided you with information concerning date, time, and venue of event(s) during the parent/student meeting held at the beginning of the school year. Transportation to and from James Madison University will be the responsibility of Augusta County, Harrisonburg City, Page County, Rockingham County, Shenandoah County, Staunton City, and Waynesboro City Public Schools.

II. HEALTH INSURANCE, EMERGENCY INFORMATION, AND AUTHORIZATION

a. Students (parent or legal guardian) are responsible for providing their own health insurance.

b. The following person should be contacted in case of emergency

| Name: __________________________ | Relationship: ___________________ | Telephone: ___________________
| Address: ________________________ | City __________________, State __________ Zip __________ |

c. If you become injured or ill while participating in the activity, you authorize VSP staff to act on your behalf in obtaining medical treatment. Please be advised that you are fully responsible for all expenses incurred for any medical care you receive during the program.

III. RELEASE AND WAIVER

James Madison University assumes no responsibility or liability for any injuries to your person or property caused by the acts or omissions of others during transportation.

By signing this form, you are acknowledging that you have been informed about certain risks and responsibilities involved in this program and that you are knowingly and voluntarily assuming them.

By signing this form you also agree, for yourself, your heirs and assigns, to release and hold harmless James Madison University, its employees and agents, from any legal claim or liability for any bodily injury and property damage that is caused to you by the negligent act or omission of third parties while you are participating in the program.

While participating in the Valley Scholars, I will accept responsibility for maintaining good conduct and appearance, and I will follow directions at all times.

__________________________________________________________________________
Student’s Signature ____________________________ Date ______________________

If the participant is under 18, a parent or legal guardian must also sign.

__________________________________________________________________________
Parent’s or Guardian’s Signature ____________________________ Date ______________________
I, *__________________________________, hereby authorize James Madison University Health Center (Parent or Guardian: First and Last name) Services to render medical treatment, which in his/her judgment may be deemed necessary in the case of * . (Name of minor or dependent: First and Last name)

Please list any:

- Student’s Allergies: ________________________________
- Medical History (i.e. Diabetes, Asthma, Seizures, etc.): ________________________________
- List any Medications that the student is currently taking:

  ______________________________________________________

  ______________________________________________________

  ______________________________________________________

  ______________________________________________________

- Date of last Tetanus Booster: __________________

Student’s Doctor’s Name: ________________________________________________________________________________

Doctor’s phone number including area code: __________________________________________________________________

Parent or Guardian Name: *______________________________________________________________________________

Home Phone Number: * ________________________________________________________________________________

Work Phone: __________________________________________________________________________________________

Address: _____________________________________________ City __________________________________________ , State _______ Zip__________

Person to call in case of an emergency, and phone number, if different than above:

Name: ___________________________________________________________________________ Phone number: ________________

Parent’s or Guardian’s Signature ____________________________ Date ________________________

Insurance Information

Insurance Company ________________________________________________

Policy No. ______________________ Group No. ______________________

Mailing address for claims:

______________________________________________________________________________________________

Subscriber’s Name: __________________________________________________

Subscriber’s Address and Home Phone Number: _________________________________________________

Employment Address and Phone Number: __________________________________________________________