

SANTA CLARITA COMMUNITY COLLEGE DISTRICT
COMMUNITY EXTENSION PROGRAM
VOLUNTARY ACTIVITY PARTICIPATION WAIVER
RELEASE OF LIABILITY and MEDICAL TREATMENT AUTHORIZATION

Participant Name:		COC STUDENT ID #, IF APPLICABLE
Description of Activity:		
Date(s) of Activity:		
Activity Program/Department and Coordinator Name:		

I understand and acknowledge that this Community Extension Activity is voluntary.

I understand and acknowledge that this Activity and any related activities, by their very nature, pose the potential risk of serious injury/illness to individuals who participate in such activities. I also realize that the Activity may be strenuous, and that I have the option to seek the advice of a physician before I participate in this Activity. I understand and acknowledge that some of the injuries/illnesses which may result from participating in this Activity include, but are not limited to, the following:

- | | | |
|-------------------|-----------------------------------|-------------------------|
| ♦ Sprains | ♦ Head and/or back injuries | ♦ Loss of eyesight |
| ♦ Fractured bones | ♦ Paralysis | ♦ Communicable diseases |
| ♦ Unconsciousness | ♦ Activity related injury/illness | ♦ Death |

The above list is not intended to be inclusive of all injuries that may occur, but rather to inform me of the types of risks inherent in my participation in the above Activity, so that I can make a voluntary choice to participate or not participate.

I hereby acknowledge and understand that, for off-campus Activity, unless specifically advised otherwise, the District is not providing transportation and it is my responsibility to arrange for my transportation to and from the Activity. If District does provide transportation but I do not use the transportation, I am responsible to make my own arrangements and the District assumes no responsibility or liability of any kind. When providing my own transportation, I further acknowledge and agree that:

- ♦ The driver of the vehicle in which I am riding, either as driver or passenger, is not driving on behalf of, or as an agent of, the District and that District has not verified the driving record of the driver, the liability insurance on the vehicle, or the condition of the vehicle;
- ♦ The District is in no way responsible for, nor does District assume any liability for, any injury or loss which may result from my transportation.

In the event of accident or illness, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services. Further, I agree that the District and its personnel are not legally or financially responsible or liable for any claim arising from any consent given in good faith in connection with diagnosis or advised treatment.

In the event of accident or illness please notify: _____
Name Telephone

I voluntarily elect to participate in this Activity. I agree to assume any and all liability and responsibility for any and all potential risks which may be associated with participation in such Activity or any activities incidental thereto. I hereby voluntarily exempt and relieve, on behalf of myself and my heirs, executors, administrators and assigns, the Santa Clarita Community College District, College of the Canyons, its officers, agents, servants, or employees from any liability or responsibility for any property damage, personal injury, bodily injury, or wrongful death that I might sustain which is incident to and/or associated with preparing for and/or while participating in any activity in any way connected with said Activity, including travel to and from Activity locations, whether same shall arise by the negligence of any of said persons, or otherwise.

I acknowledge that I have carefully read and understand this Voluntary Activities Participation Waiver, Release of Liability and Medical Treatment Authorization and that I agree to its terms and conditions.

Signature of Participant **or, if Participant is a minor**, Parent/Guardian Date

Print Name of Participant **or, if Participant is a minor**, Parent/Guardian

Check Box if Participant is a Minor