COAST COMMUNITY COLLEGE DISTRICT

ASSUMPTION OF RISK FOR PARTICIPATION IN VOLUNTARY ACTIVITY

Participant: _____

Description of Activity ("Activity"): _____

Date(s) of Activity: _____

Activity Coordinator/Sponsor: _____

I realize that this activity is voluntary and is not part of any Coast Community College District ("District") program. I understand that this activity could cause serious illness and/or injury, and I assume all risks for any such illness and/or injury. I am aware that no District insurance coverage for medical treatment or liability is provided in connection with this activity.

I understand that pursuant to sub-section "h" of Section 55220 of Title 5 of the California Code of Regulations, by participating voluntarily in this Activity, I am deemed by law to have waived any claims against the District for injury, accident, illness, or death occurring during or by reason of the this Activity. I hereby voluntarily release, discharge, waive, and relinquish any and all actions of causes of action for personal injury, bodily injury, property damage, or wrongful death occurring to myself arising in any way whatsoever as a result of engaging in the Activity, or any activities incidental thereto, wherever or however the same may occur and for whatever period these activities may continue. For myself, my heirs, executors, administrators, and assigns, I hereby release, waive, discharge, and relinquish, any action or causes of action which may hereafter arise for myself or for my estate, and I agree that under no circumstances will I or my heirs, executors, administrators, or assigns, prosecute or present any claim for personal injury, bodily injury, property damage, or wrongful death against the District or any of its officers, agents, or employees, for any of cause of action, whether from the District's negligence or otherwise.

I have no known medical condition which may pose a risk to the health and safety of others or me by participating in the Activity). I agree to advise the District in writing of any medical, physical, or health condition, which may be affected or in any way be jeopardized by me participating in the Activity.

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

In the event of illness or injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical,, or dental diagnosis, treatment, or 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.

I hereby acknowledge and understand that the District is not providing the transportation or housing and it is my responsibility to arrange for my transportation to and from the Activity, and housing while attending the event.

As the District is not providing the transportation, I further understand that:

- The driver of the vehicle in which I am riding, either as driver or passenger, is not driving on behalf or as an agent of the District, and the 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, nor does the District assume liability, for any injury or loss which may result from my transportation.

I HEREBY ACKNOWLEDGE THAT I KNOWINGLY AND VOLUNTARILY ASSUME ALL RISK OF BODILY INJURY, AS STATED, AND EXPRESSLY ACKNOWLEDGES MY INTENTION, BY SIGNING THIS FORM, TO EXEMPT AND RELIEVE THE DISTRICT, ITS TRUSTEES, OFFICERS, AGENTS, AND EMPLOYEES, FROM ANY LIABILITY FOR PERSONAL INJURY, BODILY INJURY, PROPERTY DAMAGE, OR WRONGFUL DEATH, THAT MAY ARISE OUT OF OR IN ANY WAY CONNECTED WITH THE ACTIVITY. I HAVE READ THE FOREGOING AND HAVE VOLUNTARILY SIGNED *THIS* FORM. I AM AWARE OF THE POTENTIAL RISKS INVOLVED IN THIS ACTIVITY AND I AM FULLY AWARE OF THE LEGAL CONSEQUENCES OF SIGNING THIS FORM. I FURTHER ACKNOWLEDGE THAT THE DISTRICT DOES NOT PROVIDE LIABILITY INSURANCE FOR THIS ACTIVITY, NOR DOES THE DISTRICT PROVIDE MEDICAL COVERAGE FOR PARTICIPANTS IN THIS ACTIVITY.

_____ _____
Participant Signature Date Phone Number

_____ _____
Address City State Zip Code