****Complete this form and bring with you to your first project meeting****

Agreement for Indemnification, Release, and Consent for Emergency Treatment

I, _____ (print name), age_____, desire to participate voluntarily in the Ozaukee County 4-H Shooting Sports Project activities at Extension Ozaukee County.

I UNDERSTAND THAT I AM BEING ASKED TO READ EACH OF THE FOLLOWING PARAGRAPHS CAREFULLY. I understand that if I wish to discuss any of the terms contained in this agreement, I may contact Extension Ozaukee County at 262-284-8288.

HOLD HARMLESS, INDEMNITY AND RELEASE:

In consideration of permission for me to voluntarily participate in Ozaukee County 4-H Shooting Sports Project activities, today and on all future dates, I, for myself, my heirs, personal representatives or assigns**,** agree to defend, hold harmless, indemnify and release the Board of Regents of the Extension University of Wisconsin-Madison Ozaukee County and their officers, employees, agents, and volunteers, from and against any and all claims, demands, actions, or causes of action of any sort on account of damage to personal property, or personal injury, or death which may result from my participation in the above-listed program. This release includes claims based on the negligence of the Board of Regents of the Extension University of Wisconsin-Madison Ozaukee County, and their officers, employees, agents, and volunteers, but expressly does not include claims based on their intentional misconduct or gross negligence.

I UNDERSTAND THAT BY AGREEING TO THIS CLAUSE I AM RELEASING CLAIMS AND GIVING UP SUBSTANTIAL RIGHTS, INCLUDING MY RIGHT TO SUE.

Signature_____ **Date**_____

Parent or Guardian_____ **Date**_____
(If participant is under age 18)

CONSENT FOR EMERGENCY TREATMENT

I authorize the Extension University of Wisconsin-Madison, Ozaukee County and its designated representatives to consent, on my behalf, to any emergency medical/hospital care or treatment to be rendered upon the advice of any licensed physician.

I AGREE TO BE RESPONSIBLE FOR ALL NECESSARY CHARGES INCURRED BY ANY HOSPITALIZATION OR TREATMENT RENDERED PURSUANT TO THIS AUTHORIZATION.

Signature_____**Date**_____

Parent or Guardian_____ **Date**_____
(If participant is under age18)