CONSENT, WAIVER, RELEASE AND INDEMNITY AGREEMENT

To be completed by Covered Program:

Hawaii/Pacific Basin Area Health Education Center, John A Burns School of Medicine, University of Hawaii

(Name, dates and description of Covered Program)

Hawaii/Pacific Basin AHEC programs and activities which includes, but not limited to PHCC, CHAT, and HOSA within 2024.

To be completed by participant:

In consideration for my participation in the Covered Program, I agree to the following on behalf of myself and my heirs, executors, administrators, and personal representatives:

1. Representation of health. I understand the nature of the Covered Program and I represent that I am in good physical, mental, and emotional health and able to participate in the Covered Program. If, at any time, I believe the conditions of my participation to be unsafe, I will immediately cease further participation in the Covered Program. I further agree to and represent that in connection with my participation in the Covered Program: (a) I will be covered by a private medical and liability insurance policy, (b) I am not employed by the University of Hawai'i (or I am employed by the University of Hawai'i but not participating in connection with my employment), and (c) the University of Hawai'i will not be responsible for or required to indemnify or defend me with respect to any illness, personal or bodily injury, death, economic and property damage, severe emotional loss, and any other loss, damage, or injury (collectively the "Injuries/Damages") that I may sustain or suffer in connection with my participation in the Covered Program.

2. Assumption of risk. I understand and acknowledge the dangers and risks involved in my participation in the Covered Program including the Injuries/Damages. These Injuries/Damages may be caused by actions or inactions of myself or others participating in the Covered Program and/or the conditions where the Covered Program occurs. I acknowledge that there may be other Injuries/Damages not known to me or not readily foreseeable at this time. I fully accept and assume all risks of the Injuries/Damages resulting from my participation in the Covered Program. I have read and understood all written materials setting forth the requirements for my participation and I will observe, follow, and comply with all verbal and written instructions.

3. Waiver and release. I hereby waive, release, and discharge any and all claims, demands, actions, rights, and causes of action for any and all Injuries/Damages, known or unknown, related to, arising from, or traceable either directly or indirectly to my participation in the Covered Program (collectively the "Released Claims").

4. Indemnify, defend, and hold harmless. I accept full responsibility for my participation in the Covered Program and I agree to indemnify, defend, and hold harmless the University of Hawai'i, and its past, present and future Board of Regents, officers, employees, agents, and assigns from any and all Released Claims and any and all demands, actions, judgments, injunctions, orders, directives, penalties, assessments, liens, liabilities, losses, damages, costs, and expenses (including attorneys' fees), arising or resulting from or caused by any of my acts or omissions (or by any person for whom I am responsible) during, involving, or related to my participation in the Covered Program.

5. Photo, Video and Sound Recording Release and Consent. I authorize the University of Hawai'i and its officers, agents, employees, successors, licensees, and assigns to take and use photographs, video, and sound recordings of and/or live stream my participation in the Covered Program, and to use my name, image, likeness, appearance, and voice (collectively the "Recordings"): (a) for any legitimate purpose, including any educational, institutional, scientific, fundraising or informational purposes, (b) in perpetuity, (c) on a worldwide basis, (d) without compensation to me, (e) in any manner or media, including use on social media sites and web pages accessible to the general public, and (f) alone or in combination with other Recordings. All right, title, and interest in the Recordings belong solely to the University of Hawai'i. I understand the Covered Program may attract media coverage or be recorded, in whole or in part, for rebroadcast or retransmission, and I consent to my inclusion in such media coverage, which may appear in print media, live or replay telecast or broadcast, podcast, and/or through social media and internet postings.

I have read this Consent, Waiver, Release, and Indemnity ("Agreement") and I understand that I am giving up substantial rights, including the right to sue. I am participating in the Covered Program freely and voluntarily. I agree that: (a) the laws of the State of Hawai'i shall apply to this Agreement and (b) if any portion of the Agreement is invalid, the remainder of the Agreement shall continue in full force and effect.

Signature of Participant	Print Name	Date

MEDICAL CONSENT FORM

I consent to, and authorize any medical professional and others working under their supervision to provide medical treatment or care to me for any injury or illness arising from or related to my participation in the Covered Program and agree to pay any and all medical expenses, costs and other charges, and to release, discharge, indemnify, defend, and hold harmless the University of Hawai'i, and its regents, officers, employees, agents and assigns from and against any and all liability, claims, demands or actions arising from or connected with such medical treatment or care.

I give permission to the University of Hawai'i to undertake any emergency/urgent treatment or medical care for me that may be deemed necessary for my health. Also, if my hospitalization is deemed to be medically necessary, I give permission for my hospitalization.

Participant's Health Insurance

The University of Hawai'i requires participants to maintain personal health insurance. Please indicate private insurance coverage or Medicaid eligibility below.

Name of Insurance Company _____ Policy # _____ Group # _____

Policy Holder's Name _____ Relationship to Participant _____

If you do not have private insurance, have you applied for Medicaid? Yes _____ No _____ (If not, please do so.)

_____	_____	_____
Signature of Participant	Print Name	Date

Participant's Emergency Contact Information:

Home Phone # (____) _____ Contact Name _____

Work Phone # (____) _____ Contact Name _____

Cell Phone # (____) _____ Contact Name _____

Physician's Emergency Contact Information:

Home Phone # (____) _____ Contact Name _____

Work Phone # (____) _____ Contact Name _____

Cell Phone # (____) _____ Contact Name _____

Physician's Exchange: Phone No.: _____