



BROWN

# Brown University Ropes Course Release and Waiver

Release executed on \_\_\_\_\_, by \_\_\_\_\_ for the benefit of Brown University.

In consideration of my being permitted to participate in the Brown University Ropes Course Program, I do hereby agree to release, indemnify, and forever discharge, Brown University, including the Corporation, its Trustees, faculty, employees, staff, and other agents of and against any and all liability and responsibility for any claim or cause of action on account of any personal injury, accident, damage, expenses, or other loss caused, suffered, or incurred by myself or any other person(s) or entity during, arising out of or in any way associated, directly or indirectly, with my use of Brown University Ropes Course, or for contribution or indemnification in respect to any claim made against me by any participant in the Brown University Ropes Course Program, his/her spouse/guest, or any other person or entity in connection therewith.

I understand that parts of the Brown University Ropes Course may be physically and emotionally demanding. I affirm that the confidential medical information that I have provided is accurate and complete. I understand that failure to disclose this information could affect my own safety and those around me, and I agree to hold Brown University harmless if full disclosure of a pre-existing medical condition has not been provided. I acknowledge and represent that I am physically capable of engaging in such physical activities and that I am responsible for monitoring my condition and will refrain from, and cease participation in, any activities that I believe pose a risk to my health.

I acknowledge that I have an obligation to provide the requested medical information to the Brown University Ropes Course staff prior to my participation in the program and to disclose any injuries, or illness, I may suffer or may have suffered subsequent to by returning this form. I agree to assume all risks and hazards resulting from any undisclosed injuries or illnesses. Further, I authorize the Brown University Ropes Course staff, at any time and from time to time during the program, to take such action deemed necessary or desirable from my welfare when I am sick or disabled, including without limitation, to transport or to make arrangements to transport me to a hospital or other health care facility for treatment to be rendered to me under the general or special supervision of a nurse, dentist, physician, or surgeon licensed to practice in the state of Rhode Island.

The Brown University Ropes Course program involves a variety of activities that include warm ups, games, group initiatives, and low elements. I understand that the Brown University Ropes Course will be conducted outdoors and that it is designed to be challenging, as well as educational. I agree to follow all safety instructions given by Brown University staff during the Ropes Course program. I acknowledge that level of participation in the program activity is at all times completely voluntary and up to my choice. I recognize that there are inherent risks involved with participation in the ropes course program and that I assume the risk of physical injury, including but not limited to strains, sprains, concussions, contusions, and other injuries that would result from any of these activities.

**If an emergency occurs please contact:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Daytime Phone Number:** \_\_\_\_\_

**OVER →**

**Further, I acknowledge that I have read and understand the above statements and that if I am unable to do so, for whatever reason, I have had them read to me and am confident that the individual doing so has read and/or translated the statements truthfully and in their entirety.**

This release and consent has been executed on behalf of myself, my heirs, and assigns, and has been made with full knowledge of the possible uses involved. This instrument has been executed in and shall be interpreted according to the laws of the state of Rhode Island.

In witness, whereof, I execute this release on the day and year first above written.

\_\_\_\_\_  
Signature of Witness  
Printed Name:

\_\_\_\_\_  
Signature of Participant  
Printed Name:

**FOR SIGNATURE OF PARENTS/GUARDIANS OF PARTICIPANTS UNDER 18**

Release executed on \_\_\_\_\_, by \_\_\_\_\_ for the benefit of Brown University.

I/we, the undersigned, assert that I am/we are the parent(s) or legal guardian(s) of \_\_\_\_\_ and that I/we have been informed of and understand the nature of the Ropes Course Program in which my son/daughter/ward, \_\_\_\_\_ may appear. I have read the release and waiver with intend of binding myself/ourselves and \_\_\_\_\_, my/our respective heirs, legal representatives and assigns, I/we do hereby agree to assume any and all responsibilities and obligations placed upon my/our son/daughter/ward by the terms and conditions as stated in the release and waiver in conjunction with my/our son/daughter/ward. Additionally, I/we expressly release, indemnify, and hold harmless Brown University, including the Corporation, its Trustees, faculty, employees, staff, and other agents of and against any and all legal responsibilities during, arising out of, or in any way associated, directly, or indirectly, with his/her participation in the Ropes Course.

I acknowledge that I have an obligation to provide the requested medical information to the Brown University Ropes Course staff prior to my son/daughter/ward's participation in the program and to disclose any injuries, or illness, s/he may suffer or may have suffered subsequent to by returning this form. I agree to assume all risks and hazards resulting from any undisclosed injuries or illnesses. Further, I authorize the Brown University Ropes Course staff, at any time and from time to time during the program, to take such action deemed necessary or desirable from my son/daughter/ward's welfare when s/he is sick or disabled, including without limitation, to transport or to make arrangements to transport him/her to a hospital or other health care facility for treatment to be rendered to him/her under the general or special supervision of a nurse, dentist, physician or surgeon licensed to practice in the state of Rhode Island.

\_\_\_\_\_  
Signature of Witness  
Printed Name:

\_\_\_\_\_  
Signature  
Printed Name: