Release of Liability and Indemnification for Minor Participants of the Neuro Lab Program

ACTIVITY INFORMATION

Activity Name: Neuro Lab

Location: 3640 Colonel Glenn Hwy., Dayton, OH 45435

Date(s): _____ **Time(s)**: _____

Participant name _____

Address _____

City, State ZIP _____

Email _____ **Phone** _____

Date of birth _____

High school _____ **Graduation year** _____

PLEASE READ THIS DOCUMENT CAREFULLY BEFORE SIGNING. THIS IS A LEGALLY BINDING DOCUMENT.

In consideration for permission to participate in activities including; program curriculum and related activities; photographs, videotaping, news releases, and other publicity efforts, and access to property and facilities of Wright State University through the Neuro Lab program; I/We, the undersigned, hereby agrees to indemnify, defend, hold harmless, and be responsible to Wright State University and its Board of Trustees, directors, officers, agents, and employees from and against any or all claims, causes of action, suits, losses, costs, damages, expenses (including, but not limited to, reasonable attorney's fees), and liabilities on account of injury to, or death of, any person, or damage to, or loss of, any property resulting from or related to the above-stated activity; and hereby, specifically agree to waive all such claims.

I/We hereby certify to Wright State University that the minor indicated above has no known medical problems or conditions that would prevent him or her from participating in these activities. In case of a medical emergency, I/We authorize Wright State University or duly authorized agents thereof to transport the minor to a health facility/hospital for medical care if it is deemed necessary. I/We further authorize such physician, health care facility, or hospital to perform any emergency procedures necessary to provide the minor with medical treatment.

I/We acknowledge that Wright State University does not provide health and accident coverage to participants and agree to be financially responsible for medical bills incurred as a result of emergency medical treatment and acknowledge that I have adequate insurance and financial resources to do so.

I/We understand that this activity is performed under this specific understanding. I/We have read and understand the foregoing and voluntarily sign this Agreement with full knowledge of its significance and as my own free act and deed.

Participant name _____

Participant signature _____ **Date** _____

Parent/Guardian name _____

Parent/Guardian signature _____ **Date** _____

Parent/Guardian name _____

Parent/Guardian signature _____ **Date** _____

WRIGHT STATE UNIVERSITY

NEURO LAB