

UNIVERSITY OF CALIFORNIA, BERKELEY  
**Management, Entrepreneurship, & Technology  
Overnight Program**

Waiver of Liability, Assumption of Risk, and Indemnity Agreement

Waiver: In consideration of being permitted to participate in any way in The Management, Entrepreneurship, & Technology Overnight Program, I, for myself, my heirs, personal representatives or assigns, do hereby release, waive, discharge, and covenant not to sue The Regents of the University of California, its officers, employees, and agents from liability from any and all claims including the negligence of The Regents of the University of California, its officers, employees and agents, resulting in personal injury, accidents or illnesses (including death), and property loss arising from, but not limited to, participation in the Management, Entrepreneurship, & Technology Overnight Program.

Assumption of Risks: Participation the Management, Entrepreneurship, & Technology Overnight Program carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The specific risks vary from one activity to another, but the risks range from 1) minor injuries such as scratches, bruises, and sprains 2) major injuries such as eye injury or loss of sight, joint or back injuries, heart attacks, and concussions 3) catastrophic injuries including paralysis and death.

I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent in the Management, Entrepreneurship, & Technology Overnight Program. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.

Indemnification and Hold Harmless: I also agree to INDEMNIFY AND HOLD The Regents of the University of California HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of my involvement in the Management, Entrepreneurship, & Technology Overnight Program and to reimburse them for any such expenses incurred.

Severability: The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Acknowledgment of Understanding: I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, and understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing the agreement freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

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Printed Name of Participant	Application ID	Signature of Participant	Date
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Printed Name of Parent/ Guardian (if participant under 18)	Signature of Parent/ Guardian (if participant under 18)	Date
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## AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(I) (We), the undersigned parent(s)/guardian(s) of \_\_\_\_\_, a minor, do hereby authorize the Management, Entrepreneurship, & Technology Overnight Program, the University of California, Berkeley Health Services or attending medical personnel as agent(s) for the undersigned to consent to any X-ray examinations, anesthetic, medical or surgical diagnosis or treatment, or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code §2000 et. seq.; or any X-ray examination, anesthetic, dental or surgical diagnosis or treatment, or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code §1600 et. seq.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician or dentist, in the exercise of his/her best judgment, may deem advisable. This authorization is given pursuant to the provisions of California Family Code §6910.

(I) (We) hereby authorize any hospital, which has provided treatment to the above-named minor pursuant to the provisions of California Family Code §6910, to surrender physical custody of such minor to (my) (our) above-named agent(s) upon the completion of treatment. This authorization is given pursuant to California Health and Safety Code §1283.

These authorizations shall remain effective until 8:00am on Saturday, April 13, 2019, unless sooner revoked in writing delivered to said agent(s).

\_\_\_\_\_  
Date of Signature Signed: \_\_\_\_\_  
Parent/Guardian

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

City: \_\_\_\_\_ State: \_\_\_\_\_

Phone No.: Home (\_\_\_\_) \_\_\_\_\_

Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

## Emergency Information

**IN CASE OF EMERGENCY NOTIFY:** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Phone: **Home** (\_\_\_\_) \_\_\_\_\_ **Work** (\_\_\_\_) \_\_\_\_\_ **Cell** (\_\_\_\_) \_\_\_\_\_

**IF DIFFERENT THAN ABOVE COMPLETE:**

**Father's Name** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Phone: **Home** (\_\_\_\_) \_\_\_\_\_ **Work** (\_\_\_\_) \_\_\_\_\_ **Cell** (\_\_\_\_) \_\_\_\_\_

**Mother's Name** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Phone: **Home** (\_\_\_\_) \_\_\_\_\_ **Work** (\_\_\_\_) \_\_\_\_\_ **Cell** (\_\_\_\_) \_\_\_\_\_

### MINOR'S PHYSICIAN

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_

Name of Medical Insurance Provider\* \_\_\_\_\_

Policy # \_\_\_\_\_ Expiration Date \_\_\_\_\_

**\*Attach a copy of your medical card**

If your son or daughter has any allergies, medical problems or is taking medication that would be important for us to be aware of, please indicate here: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_