

MINOR VOLUNTEER CONSENT AND RELEASE

WASHINGTON STATE UNIVERSITY
HUMAN RESOURCE SERVICES
PULLMAN, WA 99164-1014
509-335-4521

To be completed for WSU minor volunteers under the age of 18.
See BPPM 60.81 for complete instructions.

VOLUNTEER NAME (LAST, FIRST, MIDDLE INITIAL)	VOLUNTEER DATE OF BIRTH	DEPARTMENT	
DATES OF VOLUNTEER ACTIVITY	LOCATION OF ACTIVITY	SUPERVISOR	
DESCRIPTION OF VOLUNTEER ACTIVITY			
DESCRIPTION OF ANY MEDICAL CONDITIONS			
KNOWN ALLERGIES			
PHYSICIAN NAME AND ADDRESS		PHYSICIAN TELEPHONE	
HEALTH INSURANCE CARRIER		GROUP/POLICY NUMBER	

This release is effective for the dates of volunteer activity indicated above.

As parent or legal guardian of the above-named minor, I give my consent for the named person to participate in the indicated volunteer activities. I also waive and forever discharge claims for damages which the above-named individual, his or her heirs, executors, and administrators may accrue against Washington State University, representative agents, and University employees and officials arising from any injuries, physical or mental, suffered in connection with the indicated volunteer activities.

In case of emergency, I understand that every effort will be made to contact me. In the event that I cannot be contacted, I hereby give permission for the physician selected by the responsible University official to provide medical treatment, including surgery and hospitalization. I assume the responsibility for the payment for any such treatment.

I have read, understand, and agree to the above statements and I sign this agreement of my own free will.

NAME OF PARENT/GUARDIAN	SIGNATURE OF PARENT/GUARDIAN	DATE	
	X		
STREET ADDRESS	CITY	STATE	ZIP
HOME TELEPHONE	WORK TELEPHONE	EMPLOYER	