

Instructor's Name: **Dr. Dan Grube**

Course: **PE 361**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

### **RISK AWARENESS FORM**

I, \_\_\_\_\_ am aware in signing this document for participation in a physical education course through the Department of Health, Physical Education & Recreation at Western Carolina University of certain elements of the course that are physically and emotionally demanding. Furthermore, I understand that certain risks and dangers, such as those listed below, exist in the activities related to physical education courses. These risks include: loss or damage to personal property, personal injury due to slipping and falling, projectile objects, collision, rotational force, or traveling to and from the activity site. I have listed other dangers specific to this course below.

I acknowledge that while the Department of Health, Physical Education & Recreation through its administrators and instructors will make every reasonable effort to teach me proper skills and techniques and to minimize exposure to known risks, all hazards and danger associated with this activity cannot be foreseen. I will take personal responsibility to learn and follow the safety rules and procedures established by my instructors and will make them aware at any point in which I question my knowledge of these procedures or my ability to participate in any activity.

Other Specific Dangers:

Instructor Comments:

Due to the rugged and remote setting of some courses, access to hospital and medical facilities may be limited. By signing below, you are giving consent for medical treatment to the instructor and medical personnel in an emergency situation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

X \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Legal Guardian Signature for person under 18 years of age.

EMERGENCY MEDICAL INFORMATION

Please identify all known allergies to foods, drugs, insect bites, dust, etc., and the nature of your reaction:

Please identify and describe any disabilities or conditions which might limit your participation, including prior injuries:

If you are presently taking medication, please identify the medication and reason for its use:

In case of emergency, who should be contacted?

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Day Phone ( ) \_\_\_\_\_ Night Phone ( ) \_\_\_\_\_

I agree to allow other instructors and leaders of the course that I am attending to view my medical history information to enable better decisions to be made in the event of an accident.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_