# 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<br>X | DATE | |
|---|---|---|---|
| STREET ADDRESS | CITY | STATE | ZIP |
| HOME TELEPHONE | WORK TELEPHONE | EMPLOYER | |



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