THE UNIVERSITY OF AKRON
CONSENT TO PARTICIPATE & RELEASE OF LIABILITY

I, the undersigned, do hereby state that I wish to participate in activities sponsored by the Department/School of

_____, at The University of Akron.

I am seeking to use University transportation and/or grant funds to travel to _____. I have reviewed and thoroughly understand the COVID-19, other contagious illnesses, and other health and safety risks associated with this travel request. I have had the opportunity to consult with my personal health care provider to make an informed decision to travel.

I acknowledge all travel carries with it certain risks that cannot be mitigated. I also acknowledge traveling during the current COVID-19 pandemic creates additional and unique risks because COVID-19 is an extremely contagious disease. I understand, travel requires close person-to-person contact for a duration of time, which increases the likelihood of disease transmission, regardless of the degree of care that I and others take to reduce the risk of transmission. I understand and accept that travelling in close proximity with an individual who is COVID-19 positive increases my odds of contracting the disease, even if the COVID-19 positive individual is asymptomatic, and even if I and others are taking safety precautions.

MY PARTICIPATION IN UNIVERSITY-SUPPORTED TRAVEL IS <u>ENTIRELY</u> <u>VOLUNTARY</u>. BY ENGAGING IN UNIVERSITY-SUPPORTED TRAVEL, I HEREBY ACKNOWLEDGE AND AGREE THAT (1) I AM AWARE AND UNDERSTAND THAT TRAVELING DURING THE COVID-19 PANDEMIC IS PARTICULARLY DANGEROUS, AND INVOLVES THE INHERENT RISK OF SERIOUS ILLNESS AND/OR DEATH; AND (2) I AM VOLUNTARILY PARTICIPATING IN UNIVERSITY-SUPPORTED TRAVEL DURING THE COVID-19 PANDEMIC WITH KNOWLEDGE OF THE DANGER INVOLVED AND HEREBY AGREE TO ACCEPT AND ASSUME ANY AND ALL RISKS OF ILLNESS, INJURY, AND/OR DEATH, WHETHER CAUSED BY THE NEGLIGENCE OF THE UNIVERSITY OF AKRON OR OTHERWISE.

_____

Name of Traveler* Date

* Parent Signature also required if under the age of 18

_____

Name of Parent Date

THE UNIVERSITY OF AKRON
STUDENT EMERGENCY CONTACT INFORMATION

NAME OF DEPARTMENT/SCHOOL: _____

PERSONAL INFORMATION:

NAME_____
(LAST) (FIRST) (MI)

ADDRESS_____
(STREET)

_____
(CITY) (STATE) (ZIP CODE)

CELL PHONE (_____)_____ HOME PHONE(_____)_____

STUDENT ID NUMBER_____ BIRTHDATE_____

MEDICAL INSURANCE COMPANY_____ PHONE NUMBER_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME_____
(LAST) (FIRST) (RELATIONSHIP TO STUDENT)

ADDRESS_____
(STREET)

_____
(CITY) (STATE) (ZIP CODE)

CELL PHONE (_____)_____ HOME PHONE (_____)_____

DO YOU HAVE ANY MEDICAL PROBLEMS THAT WE NEED TO KNOW ABOUT?

No_____ Yes_____ IF YES, PLEASE EXPLAIN:_____

DO YOU HAVE ANY ALLERGIES?

No_____ Yes_____ IF YES, PLEASE EXPLAIN:_____

ARE YOU TAKING ANY MEDICATION?

No_____ Yes_____ IF YES, PLEASE EXPLAIN:_____