

**VOLUNTEER WAIVER, RELEASE AND INDEMNITY AGREEMENT**

I, \_\_\_\_\_, have agreed to volunteer my services for the Lafayette \_\_\_\_\_ activity (“Activity”). I am informed and understand that the Activity is co-sponsored by the City of Lafayette (“City”).

The work to be performed at the Activity is outlined below:

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I agree that I will not perform any work beyond the scope of work outlined above.

I further understand that the City provides no compensation for my services and that I am not entitled to any benefits from the City, including but not limited to workers' compensation benefits.

Assumption of Risk

I understand that there are risks of injury, death and damage to property from performing the Activity for the City. I attest and verify that I possess the physical fitness and ability to perform the Activity and that I have no physical limitations that would affect my performance of the Activity. If I do not feel that I am capable of performing the Activity, I assume the responsibility of informing whomever is designated as the Activity Supervisor or Manager.

In consideration for being allowed to participate in the Activity, I hereby assume the risk of, and responsibility for, any such injury, death or damage which I may sustain arising out of or in any way connected with performance of the Activity, including injury, death or damage resulting from any acts or omissions, whether negligent or not, or any property or equipment owned or supplied by or on behalf of the City, its officials, officers, employees, agents, volunteers, and any other promoters, operators or co-sponsors of the Activity.

Release and Indemnification

In consideration for being allowed to participate in the Activity, I hereby release, waive and discharge the City, its officials, officers, employees, agents, volunteers, and any other promoters, operators or co-sponsors of the Activity, from any and all liability, claims, or causes of action arising out of or in any way connected with my performance of the Activity, or upon its acts or omissions, whether negligent or not (“Waiver”). I agree to this Waiver on behalf of myself, my heirs, executors, administrators and assigns.

As further consideration for being allowed to participate in the Activity, I hereby agree, on behalf of myself, my heirs, executors, administrators and assigns, to indemnify and hold harmless the City, its officials, officers, employees, agents, volunteers, and any other

promoters, operators or co-sponsors of the Activity, from any and all claims for compensation, personal injury, property damage or wrongful death caused by my negligence or willful misconduct, in the performance of the Activity.

Knowing and Voluntary Execution

I have carefully read this Waiver and Release Form and fully understand its contents. I understand that I am giving up valuable legal rights. I knowingly and voluntarily give up these rights of my own free will.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent or Legal Guardian if under 18

\_\_\_\_\_  
Signature (Participant, or Parent/Legal Guardian if under 18)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Daytime Phone Number

\_\_\_\_\_  
Evening Phone Number

**PERSON TO CONTACT IN CASE OF EMERGENCY:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relation

\_\_\_\_\_  
Address

\_\_\_\_\_  
Daytime Phone Number

\_\_\_\_\_  
Evening Phone Number

\_\_\_\_\_  
**VOLUNTEERS UNDER 12 YEARS OF AGE SHALL BE ACCOMPANIED BY AN ADULT**

\_\_\_\_\_  
**PARENT/LEGAL GUARDIAN SHALL COMPLETE CONSENT TO MEDICAL TREATMENT OF MINOR FORM (ATTACHED) FOR ALL VOLUNTEERS UNDER 18 YEARS OF AGE**

**CONSENT TO MEDICAL TREATMENT OF MINOR**

In the event of illness, accident or injury which may occur while said Minor is engaged in the Activity, I hereby authorize and give my consent pursuant to California Family Code section 6910, to the City, its officials, officers, employees, agents, volunteers, and any other promoters, operators or co-sponsors of the Activity, to seek medical treatment for said Minor as shall be necessary under the circumstances from a physician licensed under the laws of the State of California.

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

Child's Name: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insurance Company and Policy No.: \_\_\_\_\_

Pertinent Medical History (e.g. Epilepsy, Diabetes, Asthma, Allergies to Medicine, etc.): \_\_\_\_\_

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