BOARD OF TRUSTEES OF COMMUNITY COLLEGE DISTRICT NO. 508 dba CITY COLLEGES OF CHICAGO
ASSUMPTION OF RISK – AQUATIC ACTIVITIES

Waiver and Release of all Claims

Please read this form carefully. When you sign this form you waive and release all claims for injuries a Participant might sustain arising out of their use of the facilities and participation in the activities and programs at Board of Trustees of Community Colleges District No. 508 dba City Colleges of Chicago.

I, (print name) Swim Particpant's Name , the undersigned, voluntarily makes and grants this Waiver and Assumption of Risk in favor of the Board of Trustees of Community College District No. 508, County of Cook, State of Illinois in consideration for engaging in various **AQUATIC** activities.

I do hereby waive and release the Board of Trustees of Community College District No. 508, and their employees, trustees, agents and assigns, from any and all claims whether in contract or of personal and bodily injury, property damages, losses and/or death that may arise from my participation in an activity recited above, a practicum, work experience, or field trip. I freely and voluntarily waive and release any and all rights and claims, demands, suits, liens, and damages against the Board of Trustees of Community College District No. 508, their officers, employees and agents that may result from my voluntary participation in various **AQUATIC** activities**.**

I understand and recognize that there are certain risks, dangers and perils connected with such participation, which are acknowledged as having been fully explained to me and which I fully understand, and which I nevertheless accept, assume and undertake after inquiry and investigation of extent, duration and completeness are wholly satisfactory and acceptable to me.

I assert that I am physically able to participate in such activities which may be strenuous.

I assert that I have completed and submitted to appropriate officials the Medical Questionnaire.

I further agree to use my best judgment in undertaking this activity in a responsible and safe manner.

I further agree to faithfully adhere to all safety instructions and recommendations, whether oral or written.

I hereby certify that I am a competent adult, 18 years of age or older and that I am assuming these risks of my own free will, being under no compulsion or duress.

This Waiver and Assumption of Risk may not be revoked, altered, amended, rescinded or voided without the express prior written consent of both parties.

SPONSORING COLLEGE		
College **Wright College**	Magda Szmurlo, Manager of Aquatics	Telephone **773/481-8918**

SIGNATURES

I fully understand the terms of this waiver and release, and I freely and voluntarily execute this document without any undue influence or coercion. I certify that I am at least 18 years of age.

Name	Signature	Date	
Address	City	State	Zip
Witness to Above Signature (print name)	Signature of Witness	Date	

If PARTICIPANT is under age of 18 – I certify that I am the parent or legal guardian of the PARTICIPANT named above. I grant my* permission *for the above named PARTICIPANT to participate in the ACTIVITY. I fully understand the terms of this waiver and release, and I freely and voluntarily execute this document without any influence or coercion.

Name	Signature	Date
Relationship to Participant	Telephone	Cell

EMERGENCY CONTACT INFORMATION		
Name	Relationship	Telephone
Name	Relationship	Telephone

CITY COLLEGES OF CHICAGO MEDICAL QUESTIONAIRE	**Wright College** **COLLEGE**

CONFIDENTIAL

The information provided below shall be considered highly confidential and personal in nature and shall be retained in a manner which recognizes and respects the sensitivity of the data.

PERSONAL DATA

Name (last)	Name (first)	Middle Initial
Address	City	State, Zip
Telephone	Cell Phone	Date of Birth
Parent/Guardian Name (if Minor)	Parent/Guardian Cell Phone	Parent E-Mail

EMERGENCY CONTACT DATA

Name (please print)	Relationship	Primary Phone Number
Name (please print)	Relationship	Primary Phone Number

MEDICAL HISTORY

1. Do you have a chronic Health condition? If yes, please explain below.	Yes	No
2. Do you take, regularly or sporadically, a medication or medications? If yes, please indicate specific medication and dosage schedule below.	Yes	No
Medications	Dosage	
3. Do you have a physical condition that could affect your participation in specific activities (or require special steps on our part to make your participation possible)? If yes, describe below.	Yes	No
4. Do you suffer from an allergy or allergies? If yes, please elaborate below.	Yes	No
5. Do you suffer from any skin disorder? If yes, please explain below.	Yes	No

6. General Activity Level?	Active	Sedentary	7. Gross Motor Challenges?	Yes	No
8. History of Heart Disease?	Yes	No	9. High/Low Blood Pressure?	Yes	No
10. Dizzy after Exercise?	Yes	No	11. Bone or Joint Discomfort?	Yes	No
12. Diagnosed with Epilepsy?	Yes	No	13. Diagnosed with Diabetes	Yes	No

14. Is there anything in your medical history (illness or injury) about which it would be potentially useful for a medical professional to know should the need arise to provide medical treatment? If so, please elaborate below.
15. Date of last tetanus shot?
16. If you would like to elaborate on anything further, please express below.

Student's signature attesting that all information provided is accurate	Date
Parent's signature if the Student is not 18 years of age at date of signing	Date