2018 SOUTHERN MISS ATHLETIC CAMPS

WAIVER, RELEASE AND INDEMNIFICATION AGREEMENT/ CONSENT TO MEDICAL TREATMENT/MEDIA RELEASE

EACH PARTICIPANT MUST PROVIDE THIS COMPLETED FORM PRIOR TO PARTICIPATION IN ANY CAMP ACTIVITY.

In consideration of my child being allowed to participate in this program/camp, I hereby RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE The University of Southern Mississippi, its governing board, officers, servants, agents, or employees (hereinafter referred to as RELEASEE) from any and all liability, claims, demands, or course of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me/my child, or to any property belonging to my child, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEE, or otherwise while participating in this camp or while in, on, or upon the premises where the camp/clinic is being conducted.

To the best of my knowledge, my child is in good physical condition, and I am not aware of any physical infirmity, which would place my child at risk to participate in any way with the camp's activities. I am fully aware of the risks and hazards associated with this camp. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISK OF LOSS, PROPERTY DAMAGE, OR PERSONAL INJURY, INCLUDING DEATH, that may be sustained by my child, or any loss or damage to property owned by me/my child, as a result of being engaged in the camp's activities, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEE or otherwise. I further hereby AGREE TO INDEMNIFY AND HOLD HARMLESS THE RELEASEE from any loss, liability, damage, or cost, including court costs and attorney's fees, that may accrue related to my child's participation in this camp, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEE or otherwise.

During the period of the camp, I hereby give permission for representatives of the University to administer appropriate medical attention to my child in the event of an accident, illness, or injury. I will be responsible for any and all costs of medical coverage and treatment provided not covered by insurance.

I recognize and acknowledge that the University may record my child's participation and appearance in this camp on any recorded medium (including, but not limited to video, audio, photos) for use in any form (publications, brochures, books, movie, electronic media, etc). I authorize such recording and release the University to use my child's name, likeness, and voice resulting from my child's participation in this camp for any purpose at the sole discretion of the University.

It is my express intent that this Waiver, Release and Indemnification Agreement/Consent to Medical Treatment/Media Release shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a RELEASE, WAIVER, DISCHARGE, AND COVENANT NOT TO SUE the above-named RELEASEE. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement/Consent to Medical Treatment shall be construed in accordance with the laws of the State of Mississippi. In signing this release, I acknowledge and represent that I have read and understand it and sign in voluntarily; I am at least eighteen (18) years of age and fully competent; and I execute this release for full, adequate, and complete consideration fully intending to be bound by the same.

I HAVE READ THIS WAIVER OF LIABILITY AND FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

______________________	______________________	__________	__________
Parent/Guardian Printed Name	**Signature**	**Date**	**Emergency #**

INSURANCE: This clinic carries an excess medical insurance policy to cover medical expenses for injuries/accidents that occur in the course of the clinic's activities. Medical expenses that are declined for payment through the participant's personal insurance and/or through the excess policy become the responsibility of the participant's parent/guardian.

INSURANCE INFORMATION:

______________________	______________________	______________________
Company Name	Policy Number	Policy Holder
______________________	______________________	
Group Number	Phone Number	

AMERICANS WITH DISABILITIES ACT: For individuals with disabilities requiring special accommodations, please contact the clinic director within a minimum of seven days of the first day of the clinic so the proper consideration may be given to the request.

PHYSICIAN'S STATEMENT: I hereby certify that ______________________________ has no restrictions that would prevent him/her from active and full participation in any and all activities related to the clinic.

______________________________________ ______________________

Physician's Signature Date ****Copy of recent (after July 1, 2017) school physical is acceptable in lieu of physician signature****

Known Allergies: ____ Tetanus Booster Date: _________________________

Medications camper will bring to camp: ____

****Campers who will bring prescription medication must complete additional paperwork.**