2017 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, 2016) 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.**

THE UNIVERSITY OF SOUTHERN MISSISSIPPI - YOUTH PROGRAM/CAMP

WAIVER AND CONSENT FOR MEDICAL TREATMENT, SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION, AND OVER-THE-COUNTER MEDICATION

PROGRAM/CAMP INFORMATION

Program/Camp Name: ______________________________

Date(s): ______________________ Time(s): ______________________

Location: ______________________________

The information requested on this form is intended to help inform program staff of any pre-existing medical conditions of participant. ***This information will be kept in strict confidence and will only be shared with your permission.*** The University requests the information below so that, in case of emergency, it will have accurate information so that it can provide and/or seek appropriate treatment for Participant. If Participant has a pre-existing medical condition, participation in any strenuous activities or recreational time may not be recommended. The requested medical information disclosed will not be used by the University personnel or employees to determine Participant's ability to participate safely in activities. You, as participant, parent or guardian understand that the **final determination about whether to participate is the responsibility of you and your physician**.

You are accountable for providing an accurate medical history. If Participant has any medical issue that is not requested below, but which you think is important, please include that information. It is recommended that you consult with a physician prior to participating in this Program. If you are uncertain about any preexisting medical conditions, it is your responsibility to consult with your own physician prior to participating in this Program. You understand that, if Participant chooses to participate in activities, he/she does so voluntarily and of his/her own accord and the final decision regarding participation is solely the responsibility of yourself, Participant, and your physician.

By signing your name under Medical Information, you acknowledge your agreement to the terms and conditions contained therein and you certify that all responses made on this form are complete, true, and accurate.

You understand that the University does offer an excess medical insurance policy for participants to cover medical expenses for injuries/accidents that occur in the course of the program'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.

PART 1. GENERAL INFORMATION

Participant Name (hereafter "Participant") ______________________________

Parent/Legal Guardian Name (if applicable) ______________________________

Street Address ____________________ City ______________ State ____________ Zip ________

Home or Cell Phone ____________________ Work Phone ____________________

Date of Birth ______/______/______ Gender: M ______ F ______

Please list two emergency contacts:

____________________	______________	______________	__________	__________
Emergency Contact #1 Name	Home Phone #	Work Phone #	Cell Phone #	Relation
____________________	______________	______________	__________	__________
Emergency Contact #2 Name	Home Phone #	Work Phone #	Cell Phone #	Relation

PART 2. MEDICAL INFORMATION

It is recommended that Participant consult with your physician prior to participating in this Program. If you are uncertain about any preexisting medical conditions, ***it is your responsibility to consult with your own physician*** prior to participating in this Program. Please answer all of the questions. If you answer yes to any of the following questions, please explain as indicated. Use back and/or additional paper if needed.

Physician's Name ________________________________ Phone Number __________________________

Date of most recent tetanus toxoid immunization ____

Do you have health/accident insurance? (circle one): YES NO

If yes, please indicate policy number, name and address of insurance company.

Company Name / Address _________________________________ Policy # ___________________

For the following, circle appropriate response and explain as appropriate:

Does participant have any limiting medical conditions that you or your doctor feel would limit camp participation? YES NO
If yes, identify and explain:

Is participant currently taking medication that may interfere with ability to safely participate in Program? YES NO
If yes, please indicate the medication and the condition being treated:

Does participant have a history of allergies or reactions to medications, insect stings, or plants? YES NO
If yes, please explain:

Does participant have a history of, or currently suffer from, medical condition(s) with which we need to be aware? YES NO
If yes, please explain:

Parent/Guardian Name _____________________________ **Parent/Guardian Signature** _____________________

Participant Signature ***(if 18 or older)***______________________ **Date** _______________________________________

PART 3: WAIVER AND CONSENT FOR MEDICAL TREATMENT

I, the undersigned parent/guardian, do hereby grant permission for my son/daughter/ward to receive necessary medical treatment, and give permission to The University of Southern Mississippi, through its representatives, to seek treatment for said son/daughter/ward, in the event of an injury or illness while at the University during the period of the program.

Furthermore, I accept responsibility for full payment of such medical treatment not covered by insurance. I hereby hold the University and its representatives harmless in the exercise of this authority.

Parent/Guardian Name _____________________________ **Parent/Guardian Signature** _____________________

Participant Signature ***(if 18 or older)***_____________________ **Date** _______________________________________

PART 4: AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION

Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the participant's parent or guardian. Please complete the following section to save time if your child needs any of these OTC medications during his/her stay.

Note: Unless we have parental authorization, we cannot administer ANY medications.

I hereby authorize that the following medications may be given to Participant if the need arises. You may dispense only those checked.

____Ointments for minor wound care, first aid as directed. (Antiseptic, anti-itch, anti-sting, antibiotic, sunburn)
____Tylenol/Acetaminophen as directed.
____Ibuprofen as directed.
____Throat lozenges and or spray as directed for sore throat.
____Micatin or anti-fungus treatment as directed for athlete's foot.
____Kaopectate or Imodium for diarrhea as directed.
____Milk of Magnesia, Pepto Bismol or Mylanta for upset stomach or nausea as directed.
____Rolaids or Tums for acid reflux, heartburn or indigestion as directed.
____Benadryl for swelling, hives, allergic reaction, as directed.
____Actifed or Sudafed as directed for nasal congestion or allergy relief per instructions.
____Visine or other eye drops for minor eye irritation.
____Medicated lip ointment for dry, chapped lips, lip blisters or canker sores as directed.
____Swimmer's ear drops as directed.
____Hydrocortisone ointment as directed for mild skin irritations, poison ivy, and insect bites.
____Medicated powder for skin irritation as directed.
____Robitussin or other cough syrup as directed.
____Calamine lotion for bug bites and poison ivy.
____Sunscreen
____Bug repellent
____Other (list any other approved over-the-counter drugs) ____

Program staff reserves the right to use generic equivalents when available for the name brand over-the-counter medications listed above.

I understand that such administration will not be done under the supervision of medical personnel. I also agree that any first aid treatment may be given as needed.

Any condition which is associated with fever, significant inflammation, and/or does not respond to the above outlined treatment will be followed-up by a consultation with the participant's parents. Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I understand that these over-the-counter medications are not necessarily kept on hand and available to be administered immediately.

I authorize the administration of over-the-counter medications to my child as indicated above. I shall indemnify and hold harmless the University and any of its representatives, employees or agents against any claims that may arise relating to my child being administered the above indicated over-the-counter medications. I/We have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the above referenced program.

Parent/Guardian Name __________________________ **Parent/Guardian Signature** ____________________________

Date ____

PART 5: AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

This form must be completed fully in order for the participant identified above to self-administer prescription medication during the program identified above. A separate form must be completed for **each** medication to be administered. Self-administration of medication requires the written authorization (below) of Participant's parent or legal guardian.

______ **No, my child does not need to take any prescription medication during the Program.**
(Please stop and sign the form at the bottom of the page)

______ **Yes, my child will need to take a prescription medication during the Program.**
(Please fill out the rest of this form and sign at the bottom of the page)

All prescription medications, including medications for conditions such as food, drug, or insect allergies; diabetes; asthma; or epilepsy may be brought to the Program under the condition that Participant can self-manage care and delivery of medication. Prescription medication must be in its original container labeled with the minor's name, medication name, dosage, and time/frequency of administration.

AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication name:____ Dose:____

Condition(s) for which medication is being administered: ____

Specific directions (e.g., on empty stomach, with water): ____

Time/frequency of administration: ____

If PRN, frequency: ____

If PRN, for what symptom(s): ____

Relevant side effect(s): ____

Medication shall be administered from (date) ____________________ to ____________________

Special storage requirements:____

Is Participant capable of self-managed care: YES NO

Prescribing health professional's name: ____

I hereby authorize and recommend Participant to self-administer the above-described medication. I hereby affirm that Participant has been instructed in the proper self-administration of the above-described medication.

Parent/Guardian Name ____________________________ **Parent/Guardian Signature** ________________________

Date ____