

**ATHLETIC CAMP RELEASE, WAIVER, AND AGREEMENT NOT TO SUE**

1. Participant \_\_\_\_\_ desires to participate in the following athletic camp \_\_\_\_\_ to be held on the following date or dates \_\_\_\_\_ by BGSU and Co-Sponsor **Falcon Soccer Camps LLC**.
2. For purposes of this document (the "Release"), I understand that: "Activity" refers to the athletic camp specified above, all my travel for it, and everything I do in connection with it; "BGSU" refers to Bowling Green State University; the University's Trustees, officers, agents, and employees; any students who are performing tasks for the University; and the State of Ohio; and "Sponsors" refers to BGSU and the Co-Sponsor and its agents and employees, individually and collectively.
3. I understand and appreciate that the Activity involves exposure to dangers and hazards, including ones that I may not know about or anticipate, which may result in property damage, economic loss, bodily or mental injury, or death. I also understand that the Sponsors may not be trained to care for problems that occur in connection with the Activity.
4. In consideration of being allowed to participate in the Activity, I agree that:
  - a. My participation in the Activity is entirely voluntary;
  - b. The Sponsors are not responsible for my personal safety or the safety of my property as I participate in the Activity;
  - c. My health does not preclude or restrict my participation in the Activity;
  - d. I have adequate health and hospitalization insurance;
  - e. The Sponsors have permission to authorize emergency medical treatment for me; and
  - f. The Sponsors have no responsibility for any injury that might occur in connection with that treatment.
5. Also in consideration of being allowed to participate in the Activity, I agree:
  - a. To fully assume all the risks and responsibilities of participating in the Activity;
  - b. To release, waive, and forever discharge any and all claims against the Sponsors for any injury to me or damage to my property resulting from the negligence of the Sponsors or anyone else involved with the Activity; and
  - c. Not to sue the Sponsors, or to seek any money from them or a judgment against them, for any injury to me or damage to my property resulting from the negligence of the Sponsors or anyone else involved with the Activity.
6. I acknowledge and represent that I have carefully read this Release and understand its contents and that I sign it as my own free act and deed. I further state that I am at least eighteen (18) years of age, fully competent to sign this Release, and that the consideration for signing this Release is full and adequate.
7. It is my express intent that, while I am alive, this Release will bind me, my spouse, and the members of my family; and that in the event of my death, this Release will also bind my estate, heirs, administrators, personal representatives, and assigns.
8. I further agree that this Release will be construed under the laws of the State of Ohio, and if any provision of this Release is found to be invalid, the remainder of it will remain valid. If I drive a vehicle in connection with the Activity, I certify that I have a valid driver's license and personally carry automobile liability insurance that includes medical payments coverage.

**THIS DOCUMENT IS A RELEASE OF LEGAL RIGHTS. BE CERTAIN YOU READ IT BEFORE SIGNING.  
IF YOU ARE UNDER 18, THIS FORM MUST BE SIGNED BY YOUR PARENT OR GUARDIAN BEFORE PARTICIPATING IN THE ACTIVITY.**

*(For the parent or guardian):* I acknowledge and represent that I have carefully read this Release; that I sign it as my own free act and deed; that I am fully competent to sign this Release; and that the consideration for signing this Release is full and adequate. It is my express intent that, while I am alive, this Release will bind me, my child or ward, my spouse, and the members of my family; and that in the event of my death, this Release will also bind my estate, heirs, administrators, personal representatives, and assigns.

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

(Print) Parent or Guardian : \_\_\_\_\_

**MEDICAL HISTORY AND CONSENT FOR EMERGENCY MEDICAL TREATMENT**

**Directions:** Parents/Guardians of minors must complete this form for program staff to provide routine health care and seek emergency medical treatment. Please answer all questions.

**PARTICIPANT INFORMATION**

Participant's Name _____	Gender _____
Home Address _____	Date of Birth _____ Age _____
City/State/Zip _____	Home Phone _____
Name of Program Attending _____	From ___/___/___ To ___/___/___
Overnight <input type="checkbox"/> Yes <input type="checkbox"/> No	

**EMERGENCY NOTIFICATION (PARENT OR GUARDIAN)**

**Before a participant under 18 years of age can be treated, the law requires us to obtain parent/guardian consent for treatment. Accordingly, for the safety and well-being of the participant, please provide us with as many phone numbers as possible.**

PRIMARY CONTACT
Name _____
Relationship _____
Phone #1 _____
Phone #2 _____

SECONDARY CONTACT
Name _____
Relationship _____
Phone #1 _____
Phone #2 _____

PHYSICIAN INFORMATION
Family Physician _____
Address _____
Phone _____
DENTIST INFORMATION
Family Dentist _____
Address _____
Phone _____

SPECIALIST INFORMATION
Specialist Name _____
Address _____
Phone _____
SPORTS CAMPS ONLY:
Date of last physical examination     /     /
Sport or activity cleared for: _____
List Any Restrictions _____

**MEDICAL HISTORY** - Please indicate if the participant has any chronic childhood conditions or diseases related to the following and list details, including any activity restrictions in the space provided.

- |   |  |
|---|--|
| <input type="checkbox"/> Arthritis & Rheumatologic Conditions<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Bones & Muscles<br><input type="checkbox"/> Brain & Nervous System<br><input type="checkbox"/> Cancer & Tumors<br><input type="checkbox"/> Digestive System<br><input type="checkbox"/> Ears, Nose, Throat/Speech, & Hearing<br><input type="checkbox"/> Endocrine Glands, Growth & Diabetes | <input type="checkbox"/> Genetic, Chromosomal & Metabolic Conditions<br><input type="checkbox"/> Heart & Blood Vessels<br><input type="checkbox"/> Kidney & Urinary System<br><input type="checkbox"/> Learning Disorders<br><input type="checkbox"/> Lungs & Respiratory System<br><input type="checkbox"/> Sexual & Reproductive System<br><input type="checkbox"/> Skin Disorders<br><input type="checkbox"/> Sleep Disorders |
|---|--|

Details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Participant's Name \_\_\_\_\_

**ALLERGIES** - [ ] this person has no allergies OR [ ] this person has allergies as noted below

TYPE (INSECT, FOOD, MEDICATIONS)	DESCRIBE REACTION

[ ] **This person carries an EpiPen**

**MEDICATIONS** - [ ] this person takes NO medications OR [ ] this person takes medications as noted below

MEDICATIONS	DOSAGE	FREQUENCY	DIAGNOSIS

Note: Our program staff is unable to administer any medications, prescription or non-prescription, to participants without a signed Permission to Dispense Medication by Camp Program Staff form

**DISABILITY** - Please indicate if participant is handicapped or disabled in any way: [ ] Psychological [ ] Neurological [ ] Hearing [ ] Pulmonary [ ] Learning [ ] Mobility [ ] Other \_\_\_\_\_

**CURRENT MEDICAL CONDITIONS** - Please indicate if participant currently has any medical conditions or limitations that do not constitute a handicap or a disability that would impair or limit the participant from fully engaging in the activities of the camp for which the participant is registering, and provide a complete description of such conditions or limitations: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Please provide a copy of the front and back of insurance card OR complete the information below

Name of Policyholder \_\_\_\_\_  
 Policyholder ID # \_\_\_\_\_  
 Medical Insurer Name \_\_\_\_\_  
 Group Name \_\_\_\_\_  
 Group ID # \_\_\_\_\_

**IMMUNIZATIONS**

The participant has been immunized in accordance with the recommended immunization schedules for children and adolescents approved by the CDC and The American Academy of Pediatrics [ ] Yes [ ] No.

**CONSENT FOR MEDICAL TREATMENT**

In the event reasonable attempts to contact me are unsuccessful, **PERMISSION** is hereby granted for the examination, treatment and medical care of the participant by Falcon Health/Wood County Hospital or another duly licensed healthcare facility. **PERMISSION** is also granted to execute on behalf of the participant any admission or consent forms needed to obtain such treatment. By signing below, I agree that I have read the foregoing and consent to the terms and conditions as stated.

<b>Signature of Parent/Guardian</b>	<b>Print Name</b>	<b>Date</b>
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STAFF USE: Form Complete [ ] Yes [ ] No Reviewed by: _____ Action Needed: _____
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