Parent/Guardian Consent, Medical Release and Release from Liability Agreement

Please send to *Head Coach, Vicki Mitchell*
(We also recommend that you bring an additional copy to each camp with you)

Mail:
Vicki Mitchell, Camp Director & Head Coach
161 Alumni Arena
Buffalo, NY 14260

E-mail:
vam3@buffalo.edu

Fax:
(716) 645-6329 (must include: "ATTENTION TRACK & FIELD CAMP")

Please read the following information carefully before signing.
All blanks must be completed. Please read the following information carefully before signing.

Camp: _____ Camp Dates: _____
Participant Name: _____
Parent/Guardian Signature: _____

In consideration for allowing Participant to participate in Camp, I/we, as parents and/or guardians of Participant, agree to the following:

- Authorize Participant to participate in the Camp for the Camp Dates stated above.
- Release, indemnify and hold harmless the University at Buffalo Sports Camps from any and all damages, except for damages caused by the sole gross negligence or intentional misconduct of the University at Buffalo, arising out of the participation of Participant in the Camp.
- Prior to the commencement of the Camp, I/we were made aware of the nature of the Camp, had sufficient opportunity to inquire further, and understand the Camp has inherent risks and I/we and Participant assume, on behalf of Participant, all those inherent risks.
- While participating in the Camp, Participant is subject to the policies, rules and regulations of the University at Buffalo Sports Camps. Possession of fireworks, explosives, any weapon, illegal drugs or alcohol is prohibited and cause for immediate expulsion from the Camp. Further, any Participant repeatedly disobeying University policies, rules or regulations may be expelled from the Camp.
- Authorize University at Buffalo Sports Camps, its employees, clinicians, athletic trainers, nurses and agents (collectively, "Activity Sponsor") the authority to seek, obtain, and approve any medical care and treatment including, but not limited to x-ray examination, anesthetic, medical, dental or surgical diagnosis, or treatment and medical care which may be recommended and provided under the general supervision of any physician or surgeon, for Participant which, in their judgment, is necessary for the health and well-being of Participant during his/her participation in the Camp. I/We further agree that I/we are(am) solely responsible for any costs incurred and agree to hold the University at Buffalo, their employees and agents (collectively, "University") harmless for any liability arising out of any good faith action taken in obtaining medical treatment for Participant.

The above agreements are binding upon us, our estates, heirs, representatives and assigns.

Parent/Guardian Signature _____ Date _____

HEALTH INSURANCE INFORMATION SHEET
EVERY PARTICIPANT MUST HAVE THIS FORM ON FILE

Private insurance information must be provided, if applicable. Please be advised that, should a participant require medical attention, **you are responsible for paying any costs not covered by insurance.**

Participant Name _____ Date of Birth _____
Participant's Address _____ City & State _____
Participant's Phone Number _____ Zip Code _____

Insurance Company Name _____ Effective Date _____
Address of Insurance Company _____
City & State _____ Zip Code _____
Phone # of Insurance Company _____ Group # _____

Policyholder's Name _____ Policy # _____
Policyholder's Address _____ City & State _____
Relationship to Participant _____ Zip Code _____
Contract # _____ Employee # _____

I hereby authorize the release of any medical information which might be needed in connection with payment for medical services.

I request that payment under my medical insurance program be made directly to the provider on any bills for services rendered by that provider. I understand that I am financially responsible for all costs not paid by my medical insurance program.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

EMERGENCY INFORMATION AND CONTACTS

Please complete this form in its entirety. This information will be helpful in the unlikely event of an accident or sudden illness.

Personal Physician contact information:

Name of Personal Physician _____ Phone _____
Physician Address _____
City &State _____ Zip Code _____

Person(s) to be contacted in case of Emergency:

Name _____ Relationship _____
Address _____
City & State_____ Zip Code _____
Daytime Phone_____ Evening Phone_____Cell Phone_____

Person(s) to be contacted in case of Emergency:

Name _____ Relationship _____
Address _____
City & State_____ Zip Code _____
Daytime Phone_____ Evening Phone_____Cell Phone_____

IMMUNIZATION RECORD

REQUIRED FOR ALL CAMPERS

Please fill out this form completely or attach a physician's immunization record

Vaccination	Vaccine Date (mm/dd/yr)	Or Physician Diagnosed Disease	Or Serology Results/Date
Diptheria			
Haemophilus Influenza B (HIB)			
Hepatitis B			
Measles			
Mumps			
Rubella		**History of Rubella disease does not prove immunity**	
** OR Combined MMR **			
Poliomyelitis			
Tetanus			
Varicella (chicken pox)			Or year of illness

Other Medical Conditions

- Are there any recent/current illness/injury/existing medical conditions that the camp should be aware of?
- Are there any restrictions or limitations that need to be placed on your child's physical activity?
- Are there any special dietary needs the camp needs to be aware of?
- Are there any allergies (i.e. medications, food, insect stings, etc.)?
- Please list any other concerns medical concerns
- Does the camper carry an Epi-Pen?
- Does the camper carry an inhaler?