Southern Miss Athletic Camps

WAIVER OF LIABILITY AND INDEMNIFICATION AGREEMENT
CONSENT TO MEDICAL TREATMENT

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

In consideration of my child being allowed to participate in this clinic, **I hereby RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE** The University of Southern Mississippi or the State College Board of the State of Mississippi, and their 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 clinic or while in, on, or upon the premises where the 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 clinic's activities. I am fully aware of the risks and hazards associated with this clinic. **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 clinic'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 clinic, **WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEE** or otherwise.

During the period of the clinic, I hereby give permission for the staff of The University of Southern Mississippi Department of Intercollegiate Athletics, or the staff of the clinic 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.

It is my express intent that this Waiver of Liability and Hold Harmless Agreement/Consent to Medical Treatment shall bund 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 (within 90 days) school physical is acceptable in lieu of physician signature****

Known Allergies:_____
Tetanus Booster Date:_____

Medications camper will bring to camp:_____-_____