Camp: _____ Dates: _____
Camper: _____

OWU SPORTS CAMPS

RELEASE AND WAIVER OF LIABILITY AND INDEMNIFICATION AGREEMENT

Purpose: To release Ohio Wesleyan University from any and all liability for the claim(s) of a participating camper and/or the claim(s) of such camper's parents or legal guardian that might arise as a result of the camper's participation in the summer camp and its programs and activities.

I/We recognize the possibility and risk of injury associated with my/our child's participation in the summer camp. In consideration of Ohio Wesleyan University's accepting my/our child as a registrant for and participant in the camp, as the parent/legal guardian of _____ date of birth: _____, I/we hereby release, discharge and/or otherwise indemnify Ohio Wesleyan University and agree not to seek or to hold Ohio Wesleyan University responsible, its agents, employees, and the above-named sponsor from any claim(s) by or on behalf of the camper or myself/ourselves for injuries of any kind, including but not limited to those caused or allegedly caused by the negligence of Ohio Wesleyan University, its agents, or its employees, as a result of or in connection with the camper's participation in the summer camp and its programs and activities.

Signature of Parent/Guardian: _____ Date:_____

MEDICAL AUTHORIZATION FORM

Purpose: To enable parents and guardians to authorize medical and, or, dental treatment for any participating camper who becomes ill or injured while in any program or activity in or related to the above-named Ohio Wesleyan University summer camp, when the parents or guardians cannot be reached.

As the parent/legal guardian of _____ date of birth: _____, I/we request that, in my/our absence, the above-named camper be admitted to any hospital or medical facility for diagnosis and treatment; and, I consent to such admission, diagnosis, and treatment. I/we request, consent to, and authorize physicians, dentist, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor.

The following apply(-ies) to the above minor child (please check all that apply and leave blank if not applicable):

_____ diabetes _____ epilepsy _____ heart condition
_____ hearing loss _____ vision loss
_____ allergies to: _____ bee stings _____ foods (identify) _____medications (identify)
_____ asthma, Medication prescribed: _____
_____ physical limitations Date of last Tetanus Booster:_____

Any other medical problems which should be noted: _____
Physician:_____ Phone:_____
Dentist:_____ Phone:_____
Name of Parent/Guardian:_____
Address:_____
City/State/Zip:_____
Phone (H):_____ (W):_____ (Fax):_____
Person to be notified if parent/guardian is unavailable:_____
Phone (H):_____ (W):_____ (Fax):_____
Insurance Carrier:_____ Policy Number:_____
Signature of Parent/Guardian:_____ Date:_____