



Owl Softball Academy Camp Waiver

Liability Release and Parental Consent Form

In consideration of the acceptance of my application for the above program, I hereby waive, release, and discharge any and all claims for damages for personal injury, property damages or which may hereafter occur to me as a result of participation in Owls Softball Academy.

This release is intended to discharge in advance Florida Atlantic University, its officials, officers, employees, volunteers and agents from liability, even though that liability may arise out of perceived negligence on the part of persons mentioned above. It is understood and agreed that this waiver, release and assumption of risk is to be binding on my heirs and assignees.

Parental Consent

I give consent for my child _____ to participate in the above activities, and I execute the above liability released on their behalf. I, as a parent/guardian, have actual knowledge and appreciation of the particulars of the program and hereby voluntarily consent to said minors' participation, and assume the risk arising therefrom. I hereby give my permission for emergency medical treatment in the event I cannot be reached.

Parent/Guardian Signature: _____

Print Name: _____ **Date:** _____

Insurance

Relationship: _____ **Insurance Company:** _____

Company Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Policy Number: _____ **Type of Coverage:** *HMO/PPO*



Permission to Treat or Administer Emergency Medical

Care/Authorization to Release Medical Information

I/We, the undersigned Parents/Guardians, in the event of an emergency, give permission for the evaluation and treatment, in our absence, of the above-named student as deemed necessary by a currently licensed health care provider, hospital, emergency medical services or program staff. Every effort will be made to contact the parent/guardian. Care of the injured student will be provided as needed. Care will not be withheld until parent arrives or are notified. I/We understand that the parent/guardian is completely responsible for the financial costs incurred with treatment.

I/We, the undersigned, authorize the release of medical information, gathered in the course of a program emergency, to the listed medical care providers and emergency response personnel. I/We authorize the listed medical providers to share any "personal health care information" that will support the health of the student while in program with the designated Health Care staff.

Signature of Parent/Guardian

Date

Medical History:

My child will take daily or emergency medication during the program day. Yes No

Name of drug, dose, frequency, time to be given, date drug therapy started or to be started for each med to be given. _____

Does your child (ren) have any disease or chronic illness we should know about? Please list below: _____

Does your child currently have Asthma? Yes No... **If yes, list frequency of asthma attacks, date of last attack and meds taken:** _____

Does your child currently have Allergies? Yes No... **If your child has a strong allergic reaction to any substance, you are encouraged to bring in a completed "Authorization to Administer Medication in Program" form for oral Benadryl and/or an Injectable Epi-pen, Epi-pen Jr.**

Food/Medication Allergies: _____ **Treatment:** _____

Reaction/Reaction Time: _____

Contact Allergies (bug bites, airborne vapors, dust, pollen, lotions, latex, etc.): _____

Treatment: _____ **Reaction/Reaction Time:** _____

Has your child been diagnosed or treated for a vision, speech, or hearing impairment? Yes or No

Does your child require assistance as defined by the Americans with Disabilities Act? Yes or No
If yes, please explain: _____

Medication Policy: All routine regularly scheduled, or as needed medications and treatments administered in the program setting must be authorized in advance by a licensed health care provider. This includes nebulizer or inhaler treatments for asthma, medications, ointments, or dressing changes to the skin and all over the counter medication (OTC's) such as Tylenol, Motrin, Cough Medicine, and Cough Drops. A note from the parent/guardian does not authorize the program nurse or nurse designee to provide these treatments. Before the nurse can administer any medications or treatments the "Authorization to Administer Medication in Program" form must be completed by the parent/guardian and the student's health care provider. This form must be given to the nurse and filed in the Health Center. The parent/guardian must provide to the Health Center the prescribed medication stored in the original container with an appropriate pharmacy label on each bottle. All labels must include the student's name, dose, route and time of administration of the medication. No student is permitted to carry any medication in his/her pocket or backpack unless special permission is granted. All medication will be kept secure in a locked cabinet in the Health Center and dispensed by the Program Nurse or designee (Athletic Trainer).

I/We have read and will abide by the program's medication policy.

Parent/Guardian Signature

Date



Owl Softball Academy Photo Release Form

Permission to Use Photograph

I grant to Florida Atlantic University Athletics, its representatives and employees the right to take photographs of me and my property in connection with the above-identified subject. I authorize Owl Softball Academy. Its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Owls Softball Academy may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I _____ have read and understand the above.

Signature: _____ **Date:** _____

Organization Name: _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____