THE UNIVERSITY OF TEXAS AT AUSTIN
University Sponsored Program - Summer Sports School – SUCCESS CAMP
Division of Physical Education - Department of Kinesiology and Health Education

M E M O R A N D U M

TO: Parents/Guardians of Prospective Participants

FROM: UT Summer Sports School SUCCESS CAMP Office

RE: Required Medical/Consent Release Forms

The UT Summer Sports School SUCCESS CAMP wishes to welcome your son/daughter as a camper. Although professionals teach all of our classes, there is always a small degree of risk to the participant because of the nature of the activities. For your protection, care and safety we request that you complete the attached **Medical / Consent Release forms**.

Please review and complete the following forms:

1) RELEASE AND INDEMNIFICATION/ CONSENT FOR TREATMENT *(page 2)*

2) MEDICAL / PHYSICIAN AUTHORIZATION ***Physician's signature required*** *(page 3)*
**Proof of a physical dated within the past 12 months is also accepted*

****** YOUR CHILD WILL NOT BE ABLE TO PARTICIPATE******
until ALL FORMS are completed and turned in.

HOW TO SUBMIT FORMS:

Fax:
(512) 232-5334

Email:
Scan and email to *mrathbun@mail.utexas.edu*

Mail:
Department of Kinesiology and Health Education
Summer Sports School SUCCESS CAMP Office – BEL 222
1 University Station, D3700
Austin, TX 78712

In person:
Summer Sports School SUCCESS CAMP Office located at the University of Texas at Austin, Bellmont Hall, Room 222

Questions? Call (512) 471-5405

FORMS MUST BE RETURNED TO THE SUMMER SPORTS SCHOOL SUCCESS CAMP OFFICE

*****DO NOT BRING FORMS TO CAMP*****

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RELEASE AND INDEMNIFICATION AGREEMENT

Participant Information (please print):

Name (first & last):______________________________ Parent/Guardian: ______________________________
Participant DOB: _______________Gender: _____ Phone # Home: ______________________________
Address: ____ Work: ______________________________
City, State, Zip: __________________________________ Cell: ______________________________

INSTITUTION:
The University of Texas at Austin

DESCRIPTION OF ACTIVITY:
UT Summer Sports School – SUCCESS CAMP

CAMP:
☐ Session 1 – Success Camp
June 13 – 17, 2011
☐ Session 2 – Success Camp
June 20 – 24, 2011

I am the Parent/Guardian of the above named participant who is under eighteen years of age and am fully competent to sign this Agreement.

In consideration of my participation in the Activity and of my use of the program's facilities and equipment, I hereby accept all risk to my health and of my injury or death that may result from such participation. I hereby release the above named Institution, its governing board, officers, employees, and representatives from any liability to me, my personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to my property and for any and all illness or injury to my person, including my death, that may result from or occur during my participation in the Activity, whether caused by negligence of the Institution, its governing board, officers, employees, or representatives, or otherwise. I further agree to indemnify and hold harmless the Institution and its governing board, officers, employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from my negligent or intentional act or omission while participating in the described Activity.

I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE A RELEASE OF ALL CLAIMS AND CAUSES OF ACTION FOR PARTICIPANT'S INJURY OR DEATH OR DAMAGE TO PARTICIPANT'S PROPERTY THAT OCCURS WHILE PARTICIPATING IN THE DESCRIBED ACTIVITY AND IT OBLIGATES ME TO INDEMNIFY THE PARTIES NAMED FOR ANY LIABILITY FOR INJURY OR DEATH OF ANY PERSON AND DAMAGE TO PROPERTY CAUSED BY PARTICIPANT'S NEGLIGENT OR INTENTIONAL ACT OR OMISSION.

______________________________________ ______________________
Signature of Parent/Guardian of Participant Date

CONSENT FOR TREATMENT OF A MINOR

I, the undersigned, as the parent / guardian of ______________________________ (a minor) hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury. The attending physician, appropriate staff, and The University of Texas at Austin and its officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.
I have received a copy of the "Notice of Privacy Practices" of The University of Texas at Austin.

______________________________________ ______________________
Signature of Parent/Guardian of Participant Date

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PERTINENT MEDICAL / INSURANCE INFORMATION

To be completed by Parent/Guardian of Participant:

Participant Information (please print):
Name (first & last):______________________
Participant DOB: ______________Gender: ______
Address: ______________________
City, State, Zip: ______________________

Parent/Guardian: ______________________
Phone # Home: ______________________
Work: ______________________
Cell: ______________________

Medical:
Allergies: ______________________
Current Medications:______________________
Other Medical Conditions: ______________________

Insurance:
Policy # ______________________
ID # ______________________
Company______________________

Please list any injuries or conditions that may preclude your child from participating in this class: ______________________
____

____
Signature of Parent/Guardian of Participant

____
Date

To be completed by Physician:

PRE-ACTIVITY CLEARANCE EXAMINATION: PHYSICIAN AUTHORIZATION

I hereby certify that I have examined ______________________ (Name of Participant) and have found him/her fit to attend and participate in the *University Sponsored Summer Sports School SUCCESS CAMP*. I know of no impairments, which would limit his/her participation in all program activities except those that I have listed below. I further certify that he/she is free from any and all contagious diseases.

Restrictions and/or Comments ____
____
____

*Date of Last Tetanus Booster ____________ **Date of Physical Examination ______________
(*For informational purposes only – not required)

______________________ ______________
PHYSICIAN'S SIGNATURE **Date**

Address ______________________________ Phone ______________
City / State / Zip ______________________________

****All participants are required to have written physician clearance proclaiming them fit for program participation. The physical exam must have been completed within the last 12 months. If your physician has documented the health information on another form, a copy of that form will suffice and can be attached to this form. *Questions?* Call (512) 471-5405.**

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