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

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

Activity: Orientation  Activity Time Period: ______________________________

Activity Sponsor: N/A  Participant Name: ________________________________

Parent/Guardian Name(s): ____________________________________________ & ________________________________

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

Authorize Participant to participate in the Activity for the Activity Time Period stated above.

Release, indemnify and hold harmless the Activity Sponsor and University from any and all damages, except for damages caused by the sole gross negligence or intentional misconduct of Activity Sponsor or University, arising out of the participation of Participant in the Activity.

Prior to the commencement of the Activity, I/we were made aware of the nature of the Activity, had sufficient opportunity to inquire further, and understand the Activity has inherent risks and I/we and Participant assume, on behalf of Participant, all those inherent risks.

While participating in the Activity, Participant is subject to the policies, rules and regulations of the University and Activity Sponsor. Possession of fireworks, explosives, any weapon, illegal drugs or alcohol is prohibited and cause for immediate expulsion from the Activity. Further, any Participant repeatedly disobeying University or Activity Sponsor policies, rules or regulations may be expelled from the Activity.

Authorize Activity Sponsor, its employees, clinicians, 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 Activity. I/We further agree that I/we are(am) solely responsible for any costs incurred and agree to hold the Activity Sponsor and the Regents of the University of Michigan, their employees and agents (collectively, “University”) harmless for any liability arising out of any good faith action taken in obtaining medical treatment for Participant.

Participant hereby grants and irrevocably consents to the reproduction, publication and/or sale of photographs, images and/or other likenesses of attained by University of Michigan-Flint staff on this date. Participant agrees that the images may be used in any form and for any purpose whatsoever, including: publications, promotional matters, advertising, trade exhibition, etc. Participant hereby releases and discharges the above named and its licensees and assigns from any and all claims and demands by Participant’s heirs or assigns arising out of or in connection with the use of these photographs, images and/or likenesses.

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

Parent/Guardian Sign ________________________________  Date: ________________

Parent/Guardian Sign ________________________________  Date: ________________

Participant Sign & Date ________________________________  Date: ________________
EMERGENCY INFORMATION AND CONTACT (Please attach a copy of current medical insurance card)

Name of Personal Physician ___________________________ Phone _____________________
Physician Address ________________________________________________________________

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

Name ___________________________ Relationship ______________________________________
Address _____________________________________________________________________________
Daytime Phone __________________ Evening Phone __________________ Cell Phone __________

Name ___________________________ Relationship ______________________________________
Address _____________________________________________________________________________
Daytime Phone __________________ Evening Phone __________________ Cell Phone __________

DOES THE STUDENT CURRENTLY HAVE ANY OF THE FOLLOWING? (if yes, please describe)

Drug allergies: _________________________________________________________________

Food allergies: _________________________________________________________________

Allergies to insect bites: _________________________________________________________

Special dietary needs: ___________________________________________________________

Asthma: _________________________________________________________________________

Frequent headaches: _____________________________________________________________

Dizziness or seizures: _____________________________________________________________

Limitations of Activities: _________________________________________________________

Medications the camper is currently taking: __________________________________________

Please note: Our staff cannot administer any medications, prescription or non-prescription to participant. This includes over-the-counter medicines like Advil or Tylenol for minor headaches or pains. If the participant will need to take medications while attending our program, s/he must bring the medication to camp and assume responsibility for taking it as needed or indicated.

Roommate Request: ________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________