ATHLETIC CAMP RELEASE, WAIVER, AND AGREEMENT NOT TO SUE

1. Participant _____desires to participate in the following athletic camp _____to be held on the following date or dates _____ by BGSU and Co-Sponsor Falcon Soccer Camps LLC.

2. For purposes of this document (the "Release"), I understand that: "Activity" refers to the athletic camp specified above, all my travel for it, and everything I do in connection with it; "BGSU" refers to Bowling Green State University; the University's Trustees, officers, agents, and employees; any students who are performing tasks for the University; and the State of Ohio; and "Sponsors" refers to BGSU and the Co-Sponsor and its agents and employees, individually and collectively.

3. I understand and appreciate that the Activity involves exposure to dangers and hazards, including ones that I may not know about or anticipate, which may result in property damage, economic loss, bodily or mental injury, or death. I also understand that the Sponsors may not be trained to care for problems that occur in connection with the Activity. **Furthermore, an inherent risk of exposure to COVID-19 exists in any public place where people are present. COVID-19 is highly contagious and can lead to severe illness and death. Although Bowling Green State University is following public health guidelines to reduce the spread of infection, I realize that I cannot be protected from all risk of illness caused by COVID-19. As a participant in the Activity and by my use of the property, facilities and/or services of BGSU to facilitate such Activity, I voluntarily assume all risks related to exposure to COVID-19.**

4. In consideration of being allowed to participate in the Activity, I agree that:
   a. My participation in the Activity is entirely voluntary;
   b. The Sponsors are not responsible for my personal safety or the safety of my property as I participate in the Activity;
   c. My health does not preclude or restrict my participation in the Activity;
   d. I have adequate health and hospitalization insurance;
   e. The Sponsors have permission to authorize emergency medical treatment for me; and
   f. The Sponsors have no responsibility for any injury that might occur in connection with that treatment.

5. Also in consideration of being allowed to participate in the Activity, I agree:
   a. To fully assume all the risks and responsibilities of participating in the Activity;
   b. To release, waive, and forever discharge any and all claims against the Sponsors for any injury to me or damage to my property resulting from the negligence of the Sponsors or anyone else involved with the Activity; and
   c. Not to sue the Sponsors, or to seek any money from them or a judgment against them, for any injury to me or damage to my property resulting from the negligence of the Sponsors or anyone else involved with the Activity.

6. I acknowledge and represent that I have carefully read this Release and understand its contents and that I sign it as my own free act and deed. I further state that I am at least eighteen (18) years of age, fully competent to sign this Release, and that the consideration for signing this Release is full and adequate.

7. It is my express intent that, while I am alive, this Release will bind me, my spouse, and the members of my family; and that in the event of my death, this Release will also bind my estate, heirs, administrators, personal representatives, and assigns.

8. I further agree that this Release will be construed under the laws of the State of Ohio, and if any provision of this Release is found to be invalid, the remainder of it will remain valid. If I drive a vehicle in connection with the Activity, I certify that I have a valid driver's license and personally carry automobile liability insurance that includes medical payments coverage.

THIS DOCUMENT IS A RELEASE OF LEGAL RIGHTS. BE CERTAIN YOU READ IT BEFORE SIGNING. IF YOU ARE UNDER 18, THIS FORM MUST BE SIGNED BY YOUR PARENT OR GUARDIAN BEFORE PARTICIPATING IN THE ACTVITY.

Signature:_____ Date:_____

Print Name:_____

(*For the parent or guardian*): I acknowledge and represent that I have carefully read this Release; that I sign it as my own free act and deed; that I am fully competent to sign this Release; and that the consideration for signing this Release is full and adequate. It is my express intent that, while I am alive, this Release will bind me, my child or ward, my spouse, and the members of my family; and that in the event of my death, this Release will also bind my estate, heirs, administrators, personal representatives, and assigns.

(Print) Parent or Guardian	Signature	Date

GC Review 4/27/21

BGSU
Bowling Green State University

MEDICAL HISTORY AND CONSENT FOR EMERGENCY MEDICAL TREATMENT

Directions: Parents/Guardians of minors must complete this form for program staff to provide routine health care and seek emergency medical treatment. Please answer all questions.

PARTICIPANT INFORMATION

Participant's Name_____Gender_____
Home Address_____Date of Birth_____Age_____
City/State/Zip_____Home Phone_____
Name of Program Attending _____From ___/___/___ To ___/___/____
Overnight ☐ Yes ☐ No

EMERGENCY NOTIFICATION (PARENT OR GUARDIAN)

Before a participant under 18 years of age can be treated, the law requires us to obtain parent/guardian consent for treatment. Accordingly, for the safety and well-being of the participant, please provide us with as many phone numbers as possible.

PRIMARY CONTACT
Name
Relationship
Phone #1
Phone #2

SECONDARY CONTACT
Name
Relationship
Phone #1
Phone #2

PHYSICIAN INFORMATION
Family Physician
Address
Phone

DENTIST INFORMATION
Family Dentist
Address
Phone

SPECIALIST INFORMATION
Specialist Name
Address
Phone

SPORTS CAMPS ONLY:
Date of last physical examination / /
Sport or activity cleared for:
List Any Restrictions

MEDICAL HISTORY - Please indicate if the participant has any chronic childhood conditions or diseases related to the following and list details, including any activity restrictions in the space provided.

- ☐ Arthristis & Rhematologic Conditions
- ☐ Asthma
- ☐ Bones & Muscles
- ☐ Brain & Nervous System
- ☐ Cancer & Tumors
- ☐ Digestive System
- ☐ Ears, Nose, Throat/Speech, &Hearing
- ☐ Endocrine Glands, Growth & Diabetes
- ☐ Genetic, Chromosomal & Metabolic Conditions
- ☐ Heart & Blood Vessels
- ☐ Kidney & Urinary System
- ☐ Learning Disorders
- ☐ Lungs & Respiratory System
- ☐ Sexual & Reproductive System
- ☐ Skin Disorders
- ☐ Sleep Disorders

Details:_____
_____
_____

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Partcipant's Name_____

ALLERGIES - ☐ this person has no allergies OR ☐ this person has allergies as noted below

TYPE (INSECT, FOOD, MEDICATIONS)	DESCRIBE REACTION

[ ] This person carries an EpiPen

MEDICATIONS - ☐ this person takes NO medications OR ☐ this person takes medications as noted below

MEDICATIONS	DOSAGE	FREQUENCY	DIAGNOSIS

Note: Our program staff is unable to administer any medications, prescription or non-prescription, to participants without a signed Permission to Dispense Medication by Camp Program Staff form

DISABILITY - Please indicate if participant is handicapped or disabled in any way: ☐ Psychological ☐ Neurological ☐ Hearing ☐ Pulmonary ☐ Learning ☐ Mobility ☐ Other_____

CURRENT MEDICAL CONDITIONS - Please indicate if participant currently has any medical conditions or limitations that do not constitute a handicap or a disability that would impair or limit the participant from fully engaging in the activities of the camp for which the participant is registering, and provide a complete description of such conditions or limitations:_____

_____

MEDICAL INSURANCE INFORMATION

Please provide a copy of the front and back of insurance card OR complete the information below

Name of Policyholder _____
Policyholder ID # _____
Medical Insurer Name _____
Group Name _____
Group ID # _____

IMMUNIZATIONS

The particpant has been immunized in accordance with the recommended immunization schedules for children and adolescents approved by the CDC and The American Academy of Pediatrics ☐ Yes ☐ No.

CONSENT FOR MEDICAL TREATMENT

In the event reasonable attempts to contact me are unsuccessful, **PERMISSION** is hereby granted for the examination, treatment and medical care of the participant by Falcon Health/Wood County Hospital or another duly licensed healthcare facility. **PERMISSION** is also granted to execute on behalf of the participant any admission or consent forms needed to obtain such treatment. By signing below, I agree that I have read the foregoing and consent to the terms and conditions as stated.

Signature of Parent/Guardian **Print Name** **Date**

STAFF USE:
Form Complete ☐ Yes ☐ No Reviewed by: Action Needed: