Camp Liability Waiver, Permission to Treat, Permission to Photograph

Participants Name (please print) _____

Liability Waiver

I hereby acknowledge that participation in the camp and related activities involves an inherent risk of physical injury or loss that might be sustained by my child. In consideration for accepting my child into camp, I assume all risk of injury and loss that may be suffered by me or my child and release and forever discharge Tim Nollan Volleyball Camps, LLC., the Board of Trustees of Northwestern University, its officers, employees and agents from any and all known liability of whatever kind or nature, arising from and by reason of any and all known and unknown, foreseen and unforeseen body and personal injuries, including death, property damage, and the consequences therefore resulting in the registrants participation in or involvement with this camp or presence on University property, including any failure or equipment or defect on the premises, except to the extent caused solely by the willful and wanton conduct of the university or Tim Nollan Volleyball Camps.

Signature _____ Date: _____
(Parent / Guardian or Attendee if 18 years old)

Permission to Treat:

As a parent or guardian, I understand that if a serious illness/injury develops, medical or hospital care is provided. I understand that an athletic trainer will be in attendance at all Tim Nollan Volleyball Camps, to provide initial medical treatment. I understand that this trainer will be rotating between gyms and may not be present to witness an injury that may occur to my child. I further understand that in case of serious illness / injury, I will receive notification. However, if it is impossible to contact me, I give my permission for emergency treatment, x-ray or surgery, as recommended by an attending physician. I approve the release of medical information pertinent to my child's care from the hospital staff to the Northwestern University Sports Medicine Staff.

_____(initial) I approve the release of insurance information to the health care provider
_____(initial) I approve the health care provider to release information to the insurance company.
_____(initial) I approve that benefits from insurance are payable to the health care provider.

I verify the above information is correct to the best of my knowledge.

Signature _____ Date: _____

Permission to give Acetaminophen Yes ____ No_____ Permission to give Ibuprofen Yes _____ No _____
(initial) ***(initial)***

Permission to Photograph

As the parent / guardian of the above named athlete, I (check one) GIVE _____ DO NOT GIVE ____ Tim Nollan Volleyball Camps permission to photograph my child, _____ while attending Tim Nollan Volleyball Camps.

I further grant Tim Nollan Volleyball Camps permission to use my child's photograph for camp purposes, including but not limited to promotions, presentations and advertising purposes. Yes _____ No _____

Signature: _____ Date: _____

Tim Nollan Volleyball Camp/Clinic Sports Medicine Information Sheet

Section A-D: To be filled out by parents (please print/type)

Section A:

Name of Participant: _____ Name of Camp attending: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Please provide the following medical information for your child:

Primary Emergency Contact

Name _____

Relationship _____

Phone Number _____

Secondary Emergency Contact

Name _____

Relationship _____

Phone Number _____

List any allergies:

Is the camper allergic to any medication? _____

If yes, please explain reaction: _____

Is the camper under the care of a physician or taking any medications? _____

If yes, please explain which medication and for which condition:

_____

Does the camper have any of the following frequently or is he/she a victim of any of the following:

_____ Nosebleeds _____ Stomach Cramps _____ Epilepsy _____ Heart Condition

_____ Diabetes _____ Seizures

**No medication will be administered or dispea

Parent's/Guardian Signature: _____

Family Physician's Name: _____

Physicians' Phone number: _____

Tim Nollan Volleyball Camps
CONSENT FOR MEDICATION ADMINSTRATION

Camper Name _____

To The Parent(s) or Legal Guardian:
If your child is under the age of 18, **Tim Nollan** Volleyball **Camps** requires your consent for medication administration or for your child's use of medical devices. The medication prescribed, non-prescribed/over the counter medicine, and/or medical device must be administered by the camp athletic trainer.

All medications must be in the original or separate medicine bottles and labeled with the camper's name. Prescription medication(s) must also include on the label the doctor's name and phone number, the medication name, and the dosage.

Complete the following information by *initialing* A, and/or B:

_____ A. There will be **NO** prescription medication(s), non-prescription(s) and/or medical devise(s) brought to camp.

_____ B. There will be the following **PRESCRIPTION** medication(s) and/or medical devise(s) brought to camp (use back of this form if needed).

Name of Medication	
Condition	
Dosage	
Time/Days to be Taken	
Prescribing Doctor	
Doctor Phone Number	
Special Instructions	

If the camper's medication is for life-threatening conditions and needs to be carried by the camper, please initial below and see the Camp Director at the check-in counter to confirm the medication plans.

_____ The medication listed above for life threatening conditions may be carried by my child (age 15 and under). Please list life threatening condition below.

ALL PARENTS/GUARDIANS **must** sign below that they have read the medication administration form and have completed it.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____ Phone Number: _____