

## Camp/Program Registration Form

Registration is not final until registration form and payment are received. Spaces may fill prior to receiving mailed registrations therefore, registration is not guaranteed. The quickest way to finalize your registration is to submit registration form and payment online.

\*Required fields

Student First and Last Name \_\_\_\_\_ Grade Level \_\_\_\_\_ School \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Telephone \_\_\_\_\_ Email Address \_\_\_\_\_

Parent/Guardian First and Last Name \_\_\_\_\_ Parent/Guardian Cell Phone \_\_\_\_\_ Alternate Contact Phone \_\_\_\_\_

### Alternate Release Contacts

First and Last Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

First and Last Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Meal Preference: \_\_\_\_\_  
Regular, Vegetarian, or Gluten-Free

T-Shirt Size: \_\_\_\_\_

*Does not apply to all programs*

Program Name / Session	Program Start Date	Program Fee
FAU Boys Soccer Camp		

### Parent/Guardian Authorization

**PHOTO/VIDEO RELEASE:** I ☐ do/ ☐ do not hereby give Florida Atlantic University permission to use my child's photograph and/or video image solely for the purposes of University-related promotional material and publications and waive any rights to compensation or ownership thereto.

**TRANSPORTATION RELEASE:** I give permission for my child to be transported to activities, riding in approved vehicles, or walking with staff to attend and participate in camp-sponsored activities on and off campus, should the program require.

**MEDICAL RELEASE:** I certify that my child is physically fit to participate and I know of no medical reason why my child should not participate. I also give permission to the leaders of this program to secure emergency medical or surgical treatment for my child if there is insufficient time to contact me, and to secure routine, non-surgical medical care as needed. ☐ I have adequate health insurance necessary to provide for and pay for any medical costs that may directly or indirectly result from my child's participation in this PRE-COLLEGIATE PROGRAM. I agree to pay for any medical costs that exceed the limits of my insurance coverage. ☐ I do not have medical insurance; I understand the University is not responsible for medical expenses that may directly or indirectly result from my child's participation in this PRE-COLLEGIATE PROGRAM.

**PERMISSION AND RELEASE OF LIABILITY:** I voluntarily assume full responsibility for any risk of loss, property damage or personal injury, including death, which may be sustained by my child as a result of his/her participation. I hereby release, waive, and discharge Florida Atlantic University and its Board of Trustees, its officers, agents, employees and representatives from all claims, demands, liabilities, rights and causes of action of whatever kind or nature, that may result from or occur during my child's participation in this PRECOLLEGIATE PROGRAM, whether caused by negligence of the UNIVERSITY, its Board of Trustees, officers, agents, employees or representatives or otherwise. I also agree to indemnify and hold harmless the UNIVERSITY for any loss, liability, damage or costs, including court costs and attorney's fees that may occur as a result of my or my child's negligent or intentional act or omission while participating in this PRECOLLEGIATE PROGRAM.

**I HAVE CAREFULLY READ THIS PERMISSION AND RELEASE OF LIABILITIES AND HAVE HAD SUFFICIENT TIME TO SEEK EXPLANATION OF THE PROVISIONS CONTAINED HEREIN, AND TO DISCUSS ANY QUESTIONS OR CONCERNS I MAY HAVE WITH THE UNIVERSITY OR ITS AFFILIATE. AFTER CAREFUL CONSIDERATION, I SIGN THIS DOCUMENT VOLUNTARILY AND WITHOUT ANY INDUCEMENT.**

Signature of Parent/Guardian\*

Date

### 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 camp 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 camp 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 camper while in program with the designated Health Care staff.

### Health Care Provider Information:

Pediatrician/Primary Health Care Provider: \_\_\_\_\_ Telephone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Telephone: \_\_\_\_\_

Insurance Coverage ☐ Yes ☐ No

Company/Carrier Name: \_\_\_\_\_

### Medical History:

**My child will take daily or emergency medication during the program day.** ☐ Yes ☐ No (If yes, must complete Authorization to Administer Medication Form)

Does your child routinely take daily medication at home? ☐ Yes ☐ No If yes, list the name, dose, time given, reason for administration, and any known side effects. \_\_\_\_\_

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 encourage to bring in a completed "Authorization to Administer Medication in Program" form for oral Benadryl and/or an injectable Epi-pen, Epi-pen Jr. These will be kept locked.

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 ☐ No

Does your child wear glasses/contacts or hearing aids? ☐ Yes ☐ No Explain: \_\_\_\_\_

Has your child been diagnosed or treated for behavioral, developmental, or learning disabilities? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Does your child require assistance as defined by the Americans with Disabilities Act? ☐ Yes ☐ 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 nurse or designee to provide these treatments. Before the nurse or designee can administer any medications or treatments the "Authorization to Administer Medication in Program" form must be completed by the parent/guardian. The parent/guardian must provide to the Director the prescribed medication stored in the original container with an appropriate pharmacy label on each bottle. All labels must include the camper's name, dose, route and time of administration of the medication. No camper 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 TOPS Office and dispensed by the nurse or designee.

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

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

### Student Behavioral Expectations(Parent/guardian to review and student to sign)

I will treat fellow students, FAU faculty, and staff with respect at all times, including: respectful listening, participation during hands-on activities, avoiding distracting behaviors, and following directions from FAU staff as necessary to ensure a safe and enjoyable experience by all. I understand that the University reserves the right to exclude my participation in this program if my participation or behavior is deemed detrimental to the safety or welfare of others. I understand that cell phones and electronic games are allowed for limited use as permitted during breaks. I understand that the consequences for breaking these rules may include; (1) a warning from the instructor; (2) meeting with the director; (3) a phone call and/or meeting with the parent/guardian; (4) being asked to leave the program without a refund.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

# 2021 MEDICAL RELEASE FORM

## Consent to medical Treatment & Release of Liability (Read this before signing below)

In consideration of being allowed to participate in this camp, related events, and activities, I hereby release, waive discharge, and covenant not to sue Florida Atlantic University, the Board of Regents of the State of Florida, and their officers, servants, agents, or employees, this camp, and its directors and employees (hereinafter referred to as release) from any and all liability, claims, demands, or course of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me/my child, or to any property belonging to me/my child, whether caused by the negligence of the release, or otherwise, while participating in the camp, or while in, on or upon the premises where the camp is being conducted.

To the best of my knowledge, I/my child am/is in good physical condition and I am not aware of any physical infirmity which would place me/my child at risk to participate in any way with camp activities. I am fully aware of risks and hazards connected with the camp. I voluntarily assume full responsibility for any risk of loss, property damage, or personal injury, or personal injury, including death, that may be sustained by me/my child, or any loss or damage to property owned by me/my child as a result of being engaged in the camp's activities, whether caused by negligence of the release or otherwise. I further here-by agree to indemnify and hold harmless the release from any loss, liability, damage, or cost, including court costs and attorney's fees, that may accrue related to me/my child's participation in this camp, whether caused by the negligence of the release or otherwise.

During the period of the camp, I hereby give permission for the staff of Florida Atlantic University or this camp to administer appropriate medical attention to me/my child in the event of an accident, illness or injury. I will be responsible for any and all costs of medical coverage and treatment provided not covered by insurance.

It is my express intent that this Waiver of Liability and Hold Harmless Agreement shall bind the member of my family and my spouse, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a release, waiver, discharge and covenant not to sue the above named release. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement shall be construed in accordance with the laws of the State of Florida. In signing this release, I acknowledge and represent that I have read and understand it and sign it voluntarily. I am at least eighteen (18) years of age and fully competent, and I execute this release for full, adequate and complete consideration fully intending to be bound by the same.

**I HAVE READ THIS WAIVER OF LIABILITY AND FULLY UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Campers Name (Print)

\_\_\_\_\_  
Medical Insurance Company Name

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Group Number

\_\_\_\_\_  
Insurance Company Phone Number

\_\_\_\_\_  
Insured's Name