

Participant Release and Waiver Form

***Please Check the Appropriate Box:** Statewide Regional/State Championship Camp Clinic

Participant's Name

Name of Parent/Legal Guardian

School/Group Name

Address

Address

Address

City State Zip

City State Zip

City State Zip

(____) _____
Home Phone

(____) _____
Work Phone/Cell Phone

(____) _____
School/Gym Phone

Minor's Social Security #

OASSA Sponsored Event Site

Squad Type (Varsity, JV, etc.)

I _____, as a parent or legal guardian of _____, a minor (hereinafter "Minor"), hereby grant the permission necessary to allow the Minor to participate in the above noted event to be sponsored by OASSA. I acknowledge and agree, on my own behalf and on the behalf of the Minor, that such participation subjects the Minor to the possibility of physical illness or injury (minimal, serious, catastrophic and/or death) and that I, on my own behalf and on behalf of the Minor, acknowledge that the Minor is assuming the risk of such illness or injury by participating in the above noted OASSA sponsored event. In the event of such illness or injury, I authorize OASSA to obtain necessary medical treatment for the Minor and hereby, on my own behalf and on the behalf of the Minor, release and hold harmless OASSA, the Hosting Site, on whose premises the Event will occur, (hereinafter the "Hosting Site"), its affiliates, the affiliates of OASSA and the respective directors, officers, representatives, members, agents and employees of OASSA, (hereinafter collectively "Releasees") in the exercise of this authority. I further acknowledge and understand that I will be responsible for any and all medical and related bills that may be incurred on behalf of the Minor for any illness or injury that the Minor may sustain during the above noted OASSA sponsored event and while traveling to and from the site for the above noted OASSA sponsored event whether or not the OASSA event actually occurs.

Appearance Agreement. I understand that OASSA at times produces promotional materials relating to its programs. I understand that as a participant in and/or spectator of the above noted OASSA sponsored event the Minor may be included in videotapes or photographs taken during the above noted OASSA sponsored event. Therefore, without reservation or limitation, I, on my own behalf and on the behalf of the Minor, hereby assign, transfer and grant to OASSA its successors, assignees, licensees, sponsors, any television networks and all other commercial exhibitors the exclusive right to photograph and/or videotape the Minor and to utilize such videotapes and photographs and Minor's name, face, likeness, voice and appearance as part of the above noted OASSA sponsored event, in advertising and promoting the above noted OASSA sponsored event or in advertising and promoting similar future events. I further understand that nether OASSA nor any third party is under any obligation to exercise any of the forgoing rights, licenses and privileges.

I, on my own behalf and on the behalf of the Minor, hereby warrant that I have read this Release and Waiver in its entirety and fully understand its contents. I, on my own behalf and on the behalf of the Minor, am aware that this Release and Waiver releases Releasees from liability and contains an acknowledgment of my voluntary and knowing assumption of the risk of injury or illness. I, on my own behalf and on the behalf of the Minor, further acknowledge that nothing in this Release and Waiver constitutes a guarantee that the above noted OASSA sponsored event will occur. I, on my own behalf and on the behalf of the Minor, have signed this document voluntarily and of my own free will.

Signature of Parent of Legal Guardian: _____ Date: _____

Relationship to Minor: _____ Minor's Birth Date: _____

Doctor's Name: _____ Doctor's Phone #: (____) _____

Dentist's Name: _____ Dentist's Phone #: (____) _____

In regard to the above mentioned person, check all that apply, **provide explanation on back of form if needed.**

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies to foods, medication, etc. | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Conditions currently under treatment |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Medications currently taking |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Pre-existing injury under treatment |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Other _____ | |

Daily Medication and Schedule: _____

Insurance Carrier: _____ Policy #: _____

Please Check One: School Insurance Participant's Family's Insurance