



# Angelo State University Camp Participant Release Agreement

Camp Name: \_\_\_\_\_ Dates: \_\_\_\_\_

Sponsor (if other than ASU): \_\_\_\_\_

**I, the undersigned, wish to participate in the above referenced camp (herein referred to as the “Camp”) and in consideration for my participation, I hereby agree as follows:**

I acknowledge and understand that participation in the Camp involves certain known dangers and risks to which I may be exposed, including but not limited to, transportation accidents, physical injuries, and loss or destruction of my property. Therefore, **I AGREE TO VOLUNTARILY ACCEPT AND ASSUME FULL RESPONSIBILITY FOR ALL SUCH DANGERS AND RISKS** both known and unknown that I may suffer while preparing, training, participating, and/or traveling to or from the Camp.

I understand and agree that Angelo State University and Sponsor cannot be expected to control all of said risks. In consideration for being allowed to participate in the Camp, I hereby expressly and knowingly **RELEASE ANGELO STATE UNIVERSITY, THE TEXAS TECH UNIVERSITY SYSTEM, SPONSOR, AND THEIR OFFICERS, AGENTS, VOLUNTEERS, AND EMPLOYEES FROM ANY AND ALL CLAIMS AND CAUSES OF ACTION I MAY HAVE FOR PROPERTY DAMAGE, PERSONAL INJURY, OR DEATH SUSTAINED BY ME ARISING OUT OF ANY TRAVEL OR ACTIVITY CONDUCTED DURING THE CAMP BY, UNDER THE AUSPICES OF, OR ON THE PROPERTY OF ANGELO STATE UNIVERSITY OR SPONSOR, WHETHER CAUSED BY MY OWN NEGLIGENCE OR THE NEGLIGENCE OF ANGELO STATE UNIVERSITY, SPONSOR, THEIR OFFICERS, AGENTS, VOLUNTEERS, OR EMPLOYEES.**

I certify that I am physically and mentally able to participate in the Camp. I understand that if I am at all uncertain about my ability to participate, it is my obligation to consult my personal physician. I hereby give my consent for any medical treatment that may be required during my participation with the understanding that the cost of any such treatment will be my responsibility.

Further, I voluntarily and knowingly agree to **HOLD HARMLESS, PROTECT, AND INDEMNIFY ANGELO STATE UNIVERSITY, THE TEXAS TECH UNIVERSITY SYSTEM, SPONSOR, AND THEIR OFFICERS, AGENTS, VOLUNTEERS, AND EMPLOYEES, AGAINST AND FROM ANY AND ALL CLAIMS, DEMANDS, OR CAUSES OF ACTION FOR PROPERTY DAMAGE, PERSONAL INJURY OR DEATH, INCLUDING DEFENSE COSTS AND ATTORNEY’S FEES, ARISING OUT OF MY PARTICIPATION IN THE CAMP, REGARDLESS OF WHETHER SUCH DAMAGES, INJURY OR DEATH ARE CAUSED BY MY OWN NEGLIGENCE, OR BY THE NEGLIGENCE OF ANGELO STATE UNIVERSITY, SPONSOR, THEIR OFFICERS, AGENTS, VOLUNTEERS, OR EMPLOYEES.**

I certify that I am at least 18 years old and I have read and understood this document and my signature evidences my intent to be bound by its terms.

Participant’s Name (Print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

If the participant is under 18 years old, I am signing as a parent or legal guardian to reflect my agreement to indemnify (that is, protect by payment or reimbursement) Angelo State University and the Texas Tech University System from any claim which may be brought by or on behalf of the participant, or any member of the participant’s family, for injury or loss resulting from those inherent risks described above, and from the negligence of the participant or Angelo State University.

Parent/Guardian Name (Print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



# Angelo State University Camp Medical Information Form

Camp Name: \_\_\_\_\_ Dates: \_\_\_\_\_

Camper's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M  F

Cell/Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

## Emergency Contact Information

Contact #1: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Contact #2: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

***All information regarding healthcare providers and medical history will be kept in strict confidence and will only be shared in case of an emergency to provide and/or seek appropriate medical treatment.***

## Healthcare Provider Information

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Health Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

Identification #: \_\_\_\_\_ Group #: \_\_\_\_\_

***\*\*Please include copy of insurance card\*\****

***I understand that if I am at all uncertain about any pre-existing medical conditions or my ability to participate in the prescribed camp activities, it is my obligation to consult with my personal physician prior to participating in this camp.***

I understand that the information requested on this form is intended to help inform camp staff of any pre-existing medical, mental, or physical conditions that I may have and that I am responsible for providing an accurate history. I also understand that my failure to disclose relevant information may result in harm to me and/or others during this camp.

I understand that by revealing or disclosing the requested information below it will not be used to determine my ability to participate safely in activities. I understand that, if I choose to participate in activities, I do so voluntarily and of my own accord and the final decision regarding participation is solely my responsibility.

Camper's Name: \_\_\_\_\_

**Medical History Information**

Please answer each question below and explain as indicated if you answer "yes" to any question.

Currently taking any medication?

Name of Medication	Strength	Dosage	Frequency	Special Instructions

Will the medication interfere with ability to safely participate in this camp?

Yes  No

If yes, please indicate the medication and possible mental/physical side effect or impact:

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List a history of, or any medical condition that you or your doctor feels would limit camp participation?

Yes  No

If yes, please identify condition and explain:

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List any allergies or reactions to foods, medications, insect stings, plants, or other materials?

Yes  No

If yes, please explain condition and course of treatment:

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Please include any additional medical issues or concerns you feel are important. \_\_\_\_\_

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***I understand that I will need to notify the Camp Director if any changes occur pertaining to my medical, mental, or physical condition prior to the scheduled camp.***

## Authorization of Treatment and Medical Release Form

I understand and agree that camp staff may, but are not obligated to, administer over-the-counter medications and/or provide first aid for minor injuries and that such treatment **will not** be done under the supervision of a healthcare provider or medical practitioner.

In case of illness or medical emergency occurring during participation in a camp or related activity, the university, camp sponsor, and their employees, volunteers, or agents may, but are not obligated to, take actions to secure whatever treatment it considers to be warranted under the circumstances. Every effort will be made to notify an emergency contact prior to treatment but this may not be practical. Before medical treatment can be provided, we are required to have a signed medical release to present to the medical provider at the time of treatment.

I \_\_\_\_\_ (*Camper's Name*) hereby authorize Angelo State University, the camp sponsor, and their employees, volunteers or agents, while participating in this camp, to administer over-the-counter medications or provide first aid treatment and to select medical treatment on my behalf to include giving permission to medical personnel to administer treatment in the event of illness or medical emergency; to release any records necessary for insurance purposes; and to provide or arrange related transportation and I agree to be solely responsible for any and all costs related to that treatment.

**I certify that all of the information provided in my medical history is correct and that I am able to participate in all prescribed camp activities. By signing my name below, I understand and agree to all the terms of this authorization and hereby give permission for this form to be printed as proof for medical treatment authorization.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**If the participant is under 18 years old; I certify as the parent or legal guardian, that as far as I know, all of the information provided in my child's medical history is correct and my child has permission to participate in all prescribed camp activities. Furthermore, I have read, understand, and agree to the terms of this authorization as indicated by my signature and hereby give permission for this form to be printed or copied as proof for my child's medical treatment authorization.**

Name (Print) \_\_\_\_\_  
(*Parent/Legal Guardian*)

Signature \_\_\_\_\_ Date \_\_\_\_\_



# Angelo State University

## Photography, Video, and Sound Recording Release

During university sponsored events, the images and/or voices of participants may be recorded in various media that are produced to chronicle or market university events.

I \_\_\_\_\_ hereby grant Angelo State University and the Texas Tech University System the right to record my voice and likeness for use in a print or media production and to make unlimited use of the photographs, videos, and/or sound recordings.

I understand the photographs, videos, and/or sound recordings may be published or distributed by means of a print publication, the internet, video recording, broadcast, podcast, cablecast, film or any similar electronic or mechanical method.

I agree that I do not own the copyright of the photographs, videos, and/or sound recordings and waive any right to inspect or approve the final uses of the photographs, videos, and/or sound recordings.

**I certify that I am at least 18 years old, have read and understand the terms of this agreement, and am legally bound to its terms as evidence by my signature.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**If the participant is under 18 years old, I am signing as the parent or legal guardian and have read and understand the terms of this agreement and am legally bound to its terms as evidence by my signature.**

Name (Print) \_\_\_\_\_  
*(Parent/Legal Guardian)*

Signature \_\_\_\_\_ Date \_\_\_\_\_