Southern Miss Football 2019 Registration Form

First Name _____ Height_____ Weight_____

Middle Name_____ Position_____

Last Name_____ Birthdate_____ Age (as of camp date) _____

Grade (Fall 2019) _____

Address_____ T-Shirt size_____

State_____ School_____

Zip Code_____ School Location_____

Email_____ Head Football Coach_____

WAIVER OF LIABILITY AND INDEMNIFACTION AGREEMENT / CONSENT TO MEDICAL TREATMENT…….

EACH PARTICIPANT MUST PROVIDE THIS COMPLETED FORM PRIOR TO PARTICIPATION IN ANY CAMP ACTIVITY. PHOTOCOPIES ARE ACCPTABLE

In consideration of my child being allowed to participate in this clinic. I hereby RELEASE, WAIVE, DISCHARGE, AND CONVENANT NOT TO SUE The University of Southern Mississippi or the State College Board of the State of Mississippi, and their officers, servants, agents, or employees (hereinafter referred to as RELEASEE) from any and all liability, claims, demands, or course of action whatsoever arising out or related to any loss, damage or injury, including death that may be sustained by me/my child, or to any property belonging to my child, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEE, or otherwise while participating in this clinic or while in, on or upon the premises where the clinic is being conducted.

To the best of my knowledge, my child is in good physical condition, and I am not aware of any physical infirmity, which would place my child at risk to participate in any way with the clinic's activities. I am fully aware of the risks and hazards associated with this clinic. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISK OF LOSS, PROPERTY, DAMAGE, OR PERSONAL INJURY, INCLUDING DEATH, that may be sustained to my child, or any loss or damage to property owned by me/my child, as a result of being engaged in the clinics activities WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEE or otherwise. I further hereby AGREE TO INDEMNIFY AND HOLD HARMLESS THE RELEASEE from any loss, liability, damage or cost, including court cost and attorney's fees, that may accrue related to my child's participation in this clinic, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEE or otherwise.

During the period of the clinic. I hereby give permission for the staff of The University of Southern Mississippi Department of Intercollegiate Athletics, or the staff of the clinic, to administer appropriate medical attention to my child in the event of an accident, illness or injury. I will be responsible for any and all cost of medical coverage and treatment provided not covered by insurance.

It Is my express intent that this Waiver of Liability and Hold Harmless Agreement/Consent to Medical Treatment shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representatives, if I am deceased and shall be deemed as a RELEASE, WAIVER, DISCHARGE, AND COVENANT NOT TO SUE the above-named RELEASEE. I hereby further agree that this Harmless Agreement/Consent to Medical Treatment shall be construed in accordance with the laws of the State of Mississippi. In signing this release , I acknowledge and represent that I have read, understand and signet 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 ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

_____ _____

PARENT/GUARDIAN PRINTED NAME PARENT/GUARDIAN SIGNATURE

_____ _____

EMERGANCY PHONE NUMBER DATE

INSURANCE INFORMATION ……..

_____ _____ _____

COMPANY NAME POLICY NUMBER POLICY HOLDER

_____ _____

GROUP NAME PHONE NUMBER

PHYCISIAN'S STATEMENT: I hereby certify that_____ has no restrictions that would prevent him/her from active and full participation in any and all activities related to the clinic

_____ _____

PHYSICIAN'S SIGNATURE DATE

Copy of recent (within one year) school physical is acceptable in lieu of physician signature

Known Allergies _____ Tetanus Booster Date: _____

Does participant have any limiting medical conditions that you or your doctor feel would limit camp participant? YES NO

If yes, identify and explain: _____

Is participant currently taking medication that may interfere with ability to safely participate in program? YES NO

If yes, please indicate the medication and the condition being treated: _____

Does the participant have a history of, or currently suffer from, medical condition(s) of which we need to be aware? YES NO

If yes, please explain:_____

Medications camper will bring to camp: _____

If participant is bringing prescription drugs to camp, additional paperwork must be completed at camp location.