CONSENT TO TREATMENT LIMITATION AND WAIVER OF LIABILITY

The undersigned hereby acknowledge that participation in this camp and related activities involves an inherent risk of physical injury, and the undersigned on behalf of the registrant, hereby assumes all such risk and does hereby release and forever discharge the camp and all employees and agents thereof, and the University of Central Florida, the University of Central Florida Board of Trustees, the University of Central Florida Athletics Association, Inc., the University of Central Florida Athletics Association, Inc. Board of Directors, and Terry Rooney Baseball Camps, LLC, any and all liability of whatever kind of nature, arising from and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries, damage to property, and the consequences thereof, resulting from this registrants participation in and or involvement with this camp, including any failure of equipment or defect in the premises. I hereby state that I am either a camper of legal age or the legal guardian of said child.

Further, I/we hereby grant permission to the staff and physicians of the University of Central Florida, any medical or surgical consultant deemed advisable, and any hospital to render to the above-named camper any medical and surgical treatment that they deem necessary. I/we understand that all possible effort will be made to inform me/us in case of such treatment.

Parent/Legal Guardian's Name (printed):_____ Signature:_____

Camper's Name (printed):_____ Signature:_____

Day Telephone:_____ Evening Telephone:_____

Emergency Contact Name:_____ Emergency Telephone:_____

CAMPER'S HEALTH FORM

To be completed and signed by camper's parents or legal guardian and camper
Please mark if pertains to camper

_____Asthma _____Diabetes _____Heart Disease _____Rheumatic Fever
_____Bleeding Disorders _____Convulsions/Seizures _____Head Injury/Concussions

Any other health concerns that we should know about:_____

Allergies to Drugs:_____ Allergies to Foods:_____

Last Tetanus Immunization (date):_____

Current Medications:_____

Chronic or Recurring Illnesses:_____

Operations/Injuries (include dates):_____

Physical Restrictions*:_____

Physician Telephone:_____ Dentist Telephone:_____

Medical Insurance:_____ Policy Number:_____

PARENT AUTHORIZATION FOR RELEASE OF INFORMATION

This health history is correct to the best of my knowledge and my son has my permission to participate in camp activities with the exception of those noted above*. I authorize the University of Central Florida Health Services to release medical information regarding the above-named participant to interested parties including parents and family physician.

Parent or Legal Guardian Must Sign Here:_____

Camper Must Sign Here:_____

I have read and I understand the camp program and application process as described in this brochure.

Parent or Legal Guardian Must Sign Here:_____

Camper Must Sign Here:_____