University of Florida Women's Basketball Team and Officials Camp

WHO: Any FHSAA Official

WHAT: High School and AAU Team Camp

WHEN: June 25-27, 2010

WHERE: University of Florida Campus

INCLUDED:
FHSAA Certification
On Campus Room and Board
FHSAA Evaluators Present
Games filmed by UF Staff
UF Basketball T-shirt

TENTATIVE AGENDA

Friday, June 25
5 pm: Registration at Women's Club next to Basketball Complex on campus

6-10 pm: Dinner and Classroom Sessions

Saturday and Sunday, June 26-27
8-10 am: Breakfast
9 am—9 pm: Games
11-1 pm: Lunch
5-7 pm: Dinner
*More Classroom Time
COST: $75
Make checks payable to: FHSAA

Name	
Address	
City, State, Zip	
Cell Number	
Email	
Driver's License #	
Date of Birth	
SS#	

Complete the above information along with the waiver included with this form and submit it to:
Officials Registrar/UF WBB Team Camp
1801 NW 80th Boulevard
Gainesville, FL 32606
Waiver and $100 must be submitted before you can participate in camp.
Please call Janna Magette at 352.375.4683 x5565 or email at jannam@gators.uaa.ufl.edu with any questions.

WAIVER OF LIABILITY

In consideration of being allowed to participate in this Camp, I hereby RELEASE, WAIVE,DISCHARGE AND COVENANT NOT TO SUE the University Athletic Association, Inc., theUniversity of Florida, the Board of Trustees of the State of Florida, the State of Florida, and their offi cers, servants, agents, or employees (hereinafter referred to as RELEASEE) 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 RELEASEE, or otherwise, while participating in this 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 infi rmity which would place me/my child at risk to participate in any way with the Camp's activities. I am fully aware of the risks and hazards connected with this Camp. IVOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISK OF LOSS, PROPERTY DAMAGE 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 THE NEGLIGENCE OF RELEASEE or otherwise. I further hereby AGREE TO INDEMNIFY AND HOLD HARMLESS, the RELEASEE, fromany loss, liability, damage or cost, including court costs and attorneys' fees, that may accrue related to me/my child's participation in the Camp, WHETHER CAUSED BY NEGLIGENCE OF RELEASEE or otherwise. During the period of the Camp, I hereby give permission for the staff of the University Athletic
Association, Inc., or this Camp to administer appropriate medical attention to me/my child in the event of any 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 consent to Medical Treatment shall bind the members of my family and spouse, if I am alive, and my heirs,assigns and personal representative, if I am deceased, and shall be deemed as a RELEASE, WAIVER, this Waiver of Liability and Hold Harmless Agreement/Consent to Medical Treatment 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 in voluntarily; I am at least eighteen (18) years of age and fully competent; and I execute this Release for full, adequate and complete considerations fully intending to be bound by 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.

____ PRINT NAME ________________________________
PARTICIPANT'S SIGNATURE

Date Signed ____________________________________

Physician'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 Camp/Clinic.

Physician's Signature __________________________ Date __________
(COPY OF RECENT (WITHIN 12 MONTHS) SCHOOL PHYSICAL ACCEPTABLE IN LIEU OFPHYSICIANSIGNATURE)

Known Allergies____Tetanus Booster Date ______________________

Medication camper will bring to camp, if any____

Insurance: This camp carries an excess medical insurance policy to cover medical expenses for injuries/accidents that occur in the course of camp activities. Medical expenses that are declined for payment through the camper's personal insurance and/or through the excess policy becomes the personal responsibility of the camper's parents/guardian.

Medical Insurance Company Name: ______________________________

Policy Number: ____

Group Number: ____

Phone Number: ____

Insured's Name: ____

<u>**American's with Disabilities Act**</u>: For Individual's with disabilities, requiring special accommodations, please contact the camp director within a minimum of seven days of the first day of camp so the proper consideration may be given to the request.