

I. Appendix B - Summer Camp Release and NCAA Compliance Attestation

For Participation in Activity in University Department of Athletics Facilities

For the purposes of this document, herein after referred to as “**Release,**” the party intending to participate (or his or her parent or guardian) in the activity in University facilities shall hereafter be referred to as “**Participant.**” The University of North Carolina at Chapel Hill, and its trustees, officers, employees and agents, acting within the course and scope of their duties, shall hereafter be referred to as “**University.**” The activity in the University facilities that the Participant will participate in shall hereafter be referred to as the “**Activity.**”

Description of Activity: SUMMER CAMP (Include description, name, and date)

- Release, Waiver of Liability, and Assumption of Risk:** In consideration of the opportunity afforded Participant to participate in the Activity in the University’s facilities, Participant hereby releases and forever discharges the University from any and all liability, claims, and demands of whatever kind or nature, either in law or in equity, which arise or may hereafter arise from or in connection with the Activity. Participant understands that this Release discharges the University from any liability or claim that Participant may have against the University with respect to any bodily injury, personal injury, illness, death, property loss, or property damage that may result from participation in the Activity. Participant understands and acknowledges that potential risks to health and personal property may be associated with participation in the Activity, and Participant voluntarily assumes those risks.
- Medical Treatment and Preexisting Medical Conditions:** Participant hereby releases and forever discharges the University from any liabilities, claims, costs and damages that arise or may hereafter arise on account of any first aid, medical treatment, or service rendered to Participant in connection with the Activity. Participant will take for herself or himself any appropriate precautions or medications to treat and/or reduce the likelihood of exacerbating any pre-existing health conditions, or insect, food or medication allergies.
Participant also hereby gives permission for the staff of the Activity to seek during the period of the Activity appropriate medical attention for the Participant in the event of accident, injury, or illness. Participant will be responsible for any and all costs of medical attention and treatment, except for that covered by the Activity’s excess medical coverage policy
- NCAA Compliance:** By signing below, Participant acknowledges that they have not knowingly participated in or become aware of any violation(s) of NCAA rules involving the University or individuals affiliated with or acting on behalf of the University. Participant’s signature below also indicates Participant’s agreement to immediately disclose to the Department of Athletics Compliance Office any NCAA rules violation(s) of which Participant becomes aware.
- Other:** This Release shall be binding and legally enforceable against Participant and Participant’s heirs, executors, administrators, and legal representatives. This Release shall be governed by and interpreted in accordance with the laws of the State of North Carolina. In the event that any clause or provision of this Release shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not otherwise affect the remaining provisions of this Release.
- No University Sponsorship:** By signing below, Participant hereby acknowledges and understands that the Activity is a privately run sports camp, and is not operated by or through The University of North Carolina at Chapel Hill. The Activity is neither sponsored, controlled, nor supervised by The University of North Carolina at Chapel Hill but rather is under the sole sponsorship, control, and supervision of the Camp Director.

I HAVE CAREFULLY READ THIS RELEASE.

<i>Name of Participant (Or Parent or Guardian if Participant is Under 18)</i>	<i>Signature of Participant (Or Parent or Guardian if Participant is Under 18)</i>	<i>Date</i>
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- Individuals (including former UNC student-athletes) who are employed as or serve as liaisons between agents, runners, or financial advisors, or whose employment is in any way related to representation of players, are not permitted to use UNC Athletics Facilities. Recruiting on behalf of or for any agent, advisor, or other professional representative outside the presence of the Department of Athletics Compliance Office in accordance with the Department of Athletics Agent and Advisor Program is strictly prohibited.
- Individuals (including former UNC student-athletes) may not provide material benefits of any kind (e.g., meals, lodging, transportation, clothing, jewelry, training expenses, etc.) directly to any current student-athlete, even former teammates, without the prior express written approval of the UNC Compliance staff.
- Should an individual wish to provide any benefits to any current UNC student-athlete, he/she must, in advance, request permission from the UNC Compliance staff.
- All Facility Users are expected to comply with all NCAA rules and Department of Athletics policies at all times. Should an individual ever have a question about any NCAA rule(s), they are expected to contact the Department of Athletics Compliance Office immediately. All Facility Users are expected to promptly notify the Department of Athletics Compliance Office should they become aware of any suspected violation of any law, NCAA rule, UNC or Department of Athletics policy, or any other regulation or legislation.

I UNDERSTAND THE ABOVE TERMS AND CONSENT TO ABIDE BY THEM.

<i>Name of Participant or Guardian</i>	<i>Signature of Participant or Guardian</i>	<i>Date</i>
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II. Appendix C - Emergency Information and Physician's Permission for Camper Participation

To be Completed by Camper or Camper's Parent/Guardian:

Camper Name: _____

Camper Age: _____

Camper's Grade: _____

Camper's Home Phone: _____

Camper's Cell Phone: _____

Camper's Email Address: _____

Home Address: _____

Home City, State, and Zip: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Cell Phone and Email: _____

Insurance Company Name: _____

Policy Holder Name: _____ Policy Number: _____

*****Please attach a photocopy of the front and back of your insurance card.***

To be Completed by Camper's Primary Physician:

Date of Last Physical Examination for this Patient: _____

Concerns about This Patient's Health of which the Camp should be Mindful:

Do you have any reservations about allowing this Camper to participate in this athletic camp on the campus of the University of North Carolina at Chapel Hill, understanding that this camp may include vigorous physical activity?

YES

NO

By signing below, you hereby declare this Patient fit for participation in this Camp.

Physician Name: _____

Physician Office Phone Number: _____

Physician Signature: _____

Date: _____

(circle one) Day Camp

Camp I

Camp II

MEDICATION AND ALLERGY FORM

Email: tarheelgymnastics@gmail.com

Mail: UNC Gymnastics P.O. Box 2126, Chapel Hill, NC 27515

My child, _____ will be taking the following medications while at gymnastics camp: (print full name)

My child is allergic to:

foods _____

medications _____

other _____

*If severe or restrictive food allergy please let us know by email to **tarheelgymnastics@gmail.com** prior to arrival at check in. We will try to accommodate all campers but it may be necessary for you to provide some meals/snacks pay additional cost involved with substitutions. We can only make special arrangements for food allergies.

Please circle the medications camp staff may administer if necessary:

Tylenol Advil Antihistamine Cough Medicine Tums

Form completed by:

Print Name _____

Signature _____

Contact numbers _() _____ () _____

Camp Medical Waiver

In the event of injury, illness, or other condition that in the judgement of the camp staff needs medical care (whether from a physician, nurse, paramedic, athletic trainer, physical therapist or other medical provider). I hereby give my consent for the camp staff to obtain such care and for such care to be given. I consent to the signing of any releases by the camp staff which may be required by any medical provider and to the release of any information required by the medical provider or insurance companies. I understand that the cost of any medical care is my responsibility and that the camp is not obligated to pay for such care. I understand that participation of my child/ward in the camp is at the sole risk of my child/ward. I assume that risk and hereby indemnify and hold harmless the Tar Heel Gymnastics Camps and staff members and employees from all costs, damages, or other liability arising from any acts of omissions that may occur while my child/ward attends the camp. I understand that my child/ward must be responsible for and capable of administering to herself, without assistance, any medication (insulin, allergy shots, oral medication) that is required as the result of any condition that exists prior to the start of camp. I understand that the Tar Heel Gymnastics Camps is a privately-run camp and is not operated, sponsored, controlled or supervised by or through the University of North Carolina at Chapel Hill, but is under sole sponsorship, control, and supervision of the camp director, Derek Galvin.

Camper's Name _____

Parent signature (if Camper is under 18) _____

Date _____

Camper's Full Name _____
 Camper's Date of Birth _____

2019 Camper Physical Form

THIS FORM TO BE COMPLETED BY A PHYSICIAN

THE OBJECTIVES OF THIS EXAMINATION ARE TO DETERMINE THAT THIS CHILD:

1. Is physically fit to engage in strenuous activities without harm to himself/herself or others.
2. Has no significant infectious condition that could be transmitted to others.
3. Has no emotional or physical disorder that could not be cared for under the routine operations and programs of Camp. Some special conditions may be handled after individual discussions with Camp.

Weight: _____ Height: _____ B.P. _____

Code: () Normal; (X) Abnormal (Explain)

- | | |
|--|--|
| <input type="checkbox"/> Skin _____ | <input type="checkbox"/> Nose _____ |
| <input type="checkbox"/> Chest _____ | <input type="checkbox"/> Extremities _____ |
| <input type="checkbox"/> Eyes _____ | <input type="checkbox"/> Throat _____ |
| <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Spine _____ |
| <input type="checkbox"/> Ears _____ | <input type="checkbox"/> Teeth _____ |
| <input type="checkbox"/> Abdomen _____ | <input type="checkbox"/> Neurologic _____ |

Menstrual History: _____

Recommendations and restrictions (diet, activity restrictions): _____

Allergies: _____

Does the camper have chronic medical problems, emotional difficulties, eating disorders or behavioral issues of which you are aware?

Yes No If yes, please describe the condition: _____

Does camper take routine medications or nutritional supplements? Yes No If yes, please list medications or nutritional supplements _____

To coincide with N.C. law for school enrollment, Organization Name require the following immunizations:

*DTP / DTaP/ DT					
**dT/Tdap					
*Polio (IPV/OPV)					
***Hib					
****Hepatitis B					
*MMR (combined doses)					
*****Chicken Pox					
**Meningococcal					

*Required by NC State law
 **Required by State law if child is 12 years or older
 ***Required by State law for children born on or after 10/01/88
 ****Required by State law for children born on or after 07/01/94
 *****Required by State law for children born on or after 04/01/01

Date of most recent PPD (Mantoux) Test _____

Test results _____

(If indicated according to AAP recommendations in the Red Book)

Recommended immunizations received in addition to those above required:

Pneumococcal					
HPV					
Hep A					
BCG/IPPD					

Print or Stamp
 Physician's Name
 Address
 Phone Number

My signature indicates I have reviewed this form as well as examined this patient on _____ Date of Exam
 (within 12 months of arrival at Camp)

Signature of Physician _____