2019 Justin Wilcox Football Skills Camp

Must submit a separate application, waiver and treat & transport form for each participant. **PLEASE PRINT CLEARLY**. Incomplete or illegible forms will not be processed.

Participant Contact Information

Participants Name_____ Birth Date____/____/____
(Last) (First) (M.I.)

Phone: (____) ____ - _____ Email: _____

Address_____ City_____ St____ Zip_____

School_____ Grade in Sept. 2019_____ HS Grad Year_____

High School Coach: _____

Emergency/Medical Information (REQUIRED)

Parent/Contact_____ Phone (____) ____ - _____
(First) (Last)

Parent/Contact E-Mail **(REQUIRED)** _____
(Enrollment confirmation will be sent to this e-mail address)

Alternate Emergency Contact_____ Phone (____) ____ - _____
(Must be different from Parent/Contact Name) (Last) (First)

Doctor Information_____ Phone (____) ____ - _____
(Name)

Medical Insurance_____
(Company) (Policy #) (Exp. Date) (Policy Holder's Name)

Medical, Physical or Emotional Conditions (including allergies and disabilities)? ❒ **Yes** ❒ **No**

If Yes, please provide information to assist us:_____ Medications:

❒ **Yes** ❒ **No** List Medications (including inhalers):_____

Is your child up-to-date on all state-required Immunizations? ❒ **Yes**❒ **No**

If No, please explain:_____

Please list any other health information relevant to camp participation_____

One Day Skills Camp:

(Athletes Entering Grades 9-12)

JUNE 1: _____ **JUNE 22:** _____

Level of Competition in Fall 2019: ❒JV ❒Varsity

Yrs. Exp. _____

Position(s) _____

Height _____ **Weight** _____

NCAA RESTRICTION - Due to NCAA restrictions, camp staff members or representatives of its athletics interests shall not employ or give free or reduced admission privileges to a high school, preparatory school or two-year college athletics award winner.

NONDISCRIMINATION STATEMENT - In accordance with applicable Federal laws, SD Football Camps does not discriminate in any of its policies, procedures, or practices on the basis of race, color, national origin, sex, sexual orientation, age or handicap.

REFUND POLICY - All requests for refunds, cancellations, or transfers that cannot utilize the manually-issued process must be submitted in writing, via e-mail (admin@sdfootballcamps.com) or fax at (510). We do not rake requests for refunds, cancellations, or transfers over the phone. Camps are not prorated and participant substitutions are not allowed. NO refunds are given to campers dismissed from camp for inappropriate behavior.

Refund/Cancellation Fees: If a player is registered for camp and is unable to attend (personal or medical), a notice of cancellation must be received ONE WEEK prior to the camp start date. If notification of cancellation is received before the specified time, camp fees will be refunded minus a $10.00 administrative fee. If notification of cancellation is not received before the specified time, camp fees will not be refunded.

Participant's Name (Last, First): _____ Camp:_____

A separate waiver is needed for each participant per camp.

JUSTIN WILCOX FOOTBALL CAMPS, LLC

Waiver of Liability, Assumption of Risk, and Indemnity Agreement

Waiver: In consideration of being permitted to participate in any way in the Sonny Dykes Football Camps that I have enrolled my child in, as listed on the Registration Form; hereinafter called "The Activity," I, for myself, my heirs, personal representatives or assigns, **do hereby release, waive, discharge, and covenant not to sue** Justin Wilcox Football Camps, LLC or The Regents of the University of California, its officers, independent contractors, and agents (collectively the "Releases") from liability **from any and all claims including negligence,** resulting in personal injury, accidents or illnesses (including death), and property loss arising from, but not limited to, participation in The Activity.

_____ _____

Signature of Parent/Guardian of Minor Date Signature of Participant Date

Assumption of Risks: Participation in The Activity carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The specific risks vary from one activity to another, but the risks range from 1) minor injuries such as scratches, bruises, and sprains, 2) major injuries such as eye injury or loss of sight, joint or back injuries, heart attacks, and concussions, to 3) catastrophic injuries including paralysis and death.

I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent in The Activity. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.

Indemnification and Hold Harmless: I also agree to INDEMNIFY AND HOLD the Releasees HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of my involvement in The Activity and to reimburse them for any such expenses incurred.

Severability: The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Acknowledgment of Understanding: I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, and **understand that I am giving up substantial rights, including my right to sue**. I acknowledge that I am signing the agreement freely and voluntarily, and **intend by my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

_____ _____

Signature of Parent/Guardian of Minor Date Signature of Participant Date

Participant's Age (if minor) _____

Participant's Name (Last, First): _____ Camp:_____

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(I) (We), the undersigned parent(s)/guardian(s) of_____ , a minor, do

hereby authorize the attending medical personnel as agent(s) for the undersigned to consent to any X-ray examinations, anesthetic, medical or surgical diagnosis or treatment, or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code §2000 et. seq.; or any X-ray examination, anesthetic, dental or surgical diagnosis or treatment, or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code §1600 et. seq.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician or dentist, in the exercise of his/her best judgment, may deem advisable. This authorization is given pursuant to the provisions of California Family Code §6910.

(I) (We) hereby authorize any hospital, which has provided treatment to the above-named minor pursuant to the provisions of California Family Code §6910, to surrender physical custody of such minor to (my) (our) above named agent(s) upon the completion of treatment. This authorization is given pursuant to California Health and Safety Code §1283.

These authorizations shall remain effective until **December 31, 2019**, unless sooner revoked in writing delivered to said agent(s).

_____

Signature of Parent/Guardian of Minor Date

JUSTIN WILCOX FOOTBALL CAMPS PROGRAM PARTICIPANT AGREEMENT

- This health history is correct so far as I know, and my son/daughter has permission to engage in all prescribed camp activities, except as noted by me. My son/daughter is in good health.
- I understand that I am required to have accidental medical coverage for the child listed on this application, and I verify that the information provided on this form is accurate and true. I further understand and agree that if I do not have accidental medical coverage for the child listed on this application, I will be financially responsible for all charges and fees incurred in the rendering of said treatment.
- I understand that at the discretion of camp/program supervisor and/or staff my child may be dismissed from the camp/program, without refund, for inappropriate behavior.
- I understand that at the conclusion of the scheduled camp/program time, Justin Wilcox Football Camps, *LLC* is no longer responsible for my child.
- I give permission to use, reprint, and produce any photographs or videos taken of me or my child and written materials supplied by me or my child in the form of evaluations during the Justin Wilcox Football Camp Programs. I further understand that such material will be used for marketing purposes only.
- I give permission to Justin Wilcox Football Camps, LLC to transfer the following data to the University of California: my name, contact information, camp session(s) attended; and if my child is a camp participant, my child's name, contact information (if different from mine), date of birth and gender. I further give permission to the University to use such data in furtherance of its marketing, development, and promotion efforts, and other purposes consistent with increasing the profile and reach of the Intercollegiate Athletics Department.

_____ _____

Signature of Parent/Guardian of Minor Date Signature of Participant (18 years or older) Date

Justin Wilcox Football Camp Medication Form
Return completed form to your camp Health Care Coordinator

Name of Camper: (Last, First) _____ Date of Birth _____

Camp_____

_____

FORM MUST BE COMPLETED BEFORE ANY MEDICATION IS BROUGHT TO CAMP

This form must be completed for prescribed and non-prescribed medications by the parent/guardian the physician (for prescription medication) and contain proper signatures before any medication can be administered at camp. All medications, whether prescribed or non-prescribed, are kept in the camp office. If your physician would like your child to carry either an asthma inhaler or emergency medication (i.e. Epipen or Inhaler), PART 3 must be completed by the doctor, parent, and child.

PART 1: PARENT/GUARDIAN: Both prescribed and non-prescribed medications will be administered by authorized camp personnel in the manner and dosage given. By signing below I hereby request that authorized personnel assist this camper in taking the medication in the manner and dosage given. I understand all medications must be in their original container.

X_____
Parent/Guardian Signature Printed Name/Relationship Date

(_____)_____ (_____)_____
Main contact phone Alternate contact phone

PART 2: PHYSICIAN (Signature not needed if non-prescription medication) IF REQUIRED by Camp

Name of Medication _____ Form _____ Dose_____
(liquid, tabs, inhaler, etc.)

Schedule of Doses _____ Date to Stop Medication _____

Restrictions, Cautions, Side Effects _____

X_____
Physician Signature Printed Name Date

Physician Phone # (_____) _____ Address_____

PART 3: PERMISSION TO CARRY ASTHMA INHALERS/EPIPENS (Part I & II Must be completed)

TO BE COMPLETED BY THE PHYSICIAN: The above-named camper has been instructed in the proper use of their asthma inhaler/emergency medication. The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the asthma inhaler/emergency medication at camp. He/she understands the purpose, appropriate method, and frequency of use of asthma inhaler/emergency medication.

X_____
Physician Signature Printed Name Date

TO BE COMPLETED BY THE PARENT/GUARDIAN: I permit my child to carry the above-listed asthma inhaler/emergency medication as ordered by his/her physician.

X_____
Parent/Guardian Signature Printed Name Date

TO BE COMPLETED BY THE CAMPER: I have been instructed in the proper use of my medication and will take it as prescribed to me by my physician.

X_____
Camper Signature Printed Name Date

PART 4: CAMP DIRECTOR (to be completed by Health Care Coordinator/designated camp staff)

_____
Person(s) designated by camp Health Care Coordinator to assist camper in taking medication above

X_____
Signature of Camp Health Care Coordinator or designated camp staff Date

This information to be used by Camp Director and authorized personnel only.

FOOTBALL CAMPS