TINKER Parent/Guardian Consent, Medical Release and Release from Liability Agreement

Name of University the Participant will be attending: _____

Please read the following information carefully before signing.

Summer Workshop: TINKER **Dates:** _____

Name of Student Participant: _____

Name of Parent/Guardian: _____

In consideration for allowing the student participant to participate in a Summer Workshop, I/we, as parents and/or guardians of Participant, agree to the following:

- Authorize Participant to participate in the Summer Workshop for the Dates stated above.
- Release, indemnify and hold harmless the University hosting the Summer Workshops from any and all damages, except for damages caused by the sole gross negligence or intentional misconduct of the University, arising out of the participation of Participant in the Workshop.
- Prior to the commencement of the Workshop, I/we were made aware of the nature of the Workshop, had sufficient opportunity to inquire further, and understand the Workshop has inherent risks and I/we and Participant assume, on behalf of Participant, all those inherent risks.
- While participating in the Workshop, Participant is subject to the policies, rules and regulations of the University at Buffalo Academic Workshops. Possession of fireworks, explosives, any weapon, illegal drugs or alcohol is prohibited and cause for immediate expulsion from the Workshop. Further, any Participant repeatedly disobeying University policies, rules or regulations may be expelled from the Camp.
- Authorize the University, its employees, clinicians, athletic trainers, nurses and agents (collectively, "Activity Sponsor") the authority to seek, obtain, and approve any medical care and treatment including, but not limited to x-ray examination, anesthetic, medical, dental or surgical diagnosis, or treatment and medical care which may be recommended and provided under the general supervision of any physician or surgeon, for Participant which, in their judgment, is necessary for the health and well-being of Participant during his/her participation in the Workshop. I/We further agree that I/we are(am) solely responsible for any costs incurred and agree to hold the University, their employees and agents (collectively, "University") harmless for any liability arising out of any good faith action taken in obtaining medical treatment for Participant.

The above agreements are binding upon us, our estates, heirs, representatives and assigns.

Parent/Guardian Signature: _____ **Date:** _____

HEALTH INSURANCE INFORMATION SHEET
EVERY PARTICIPANT MUST HAVE THIS FORM ON FILE

Private insurance information must be provided, if applicable. Please be advised that, should a participant require medical attention, **you are responsible for paying any costs not covered by insurance.**

Participant Name _____ Date of Birth _____
Participant's Address _____ City & State _____
Participant's Phone Number _____ Zip Code _____

Insurance Company Name _____ Effective Date _____
Address of Insurance Company _____
City & State _____ Zip Code _____
Phone # of Insurance Company _____ Group # _____

Policyholder's Name _____ Policy # _____
Policyholder's Address _____ City & State _____
Relationship to Participant _____ Zip Code _____
Contract # _____ Employee # _____

I hereby authorize the release of any medical information which might be needed in connection with payment for medical services.

I request that payment under my medical insurance program be made directly to the provider on any bills for services rendered by that provider. I understand that I am financially responsible for all costs not paid by my medical insurance program.

Parent/Guardian Signature _____ Date _____
Parent/Guardian Signature _____ Date _____

EMERGENCY INFORMATION AND CONTACTS

Please complete this form in its entirety. This information will be helpful in the unlikely event of an accident or sudden illness.

Personal Physician contact information:
Name of Personal Physician _____ Phone _____
Physician Address _____
City &State _____ Zip Code _____

Person(s) to be contacted in case of Emergency:
Name _____ Relationship _____
Address _____
City & State_____ Zip Code _____
Daytime Phone_____ Evening Phone_____Cell Phone_____

Person(s) to be contacted in case of Emergency:
Name _____ Relationship _____
Address _____
City & State_____ Zip Code _____
Daytime Phone_____ Evening Phone_____Cell Phone_____

OTHER MEDICAL INFORMATION

Please complete the form below, elaborating as necessary.

LIST ACTIVITIES FROM WHICH THE CAMPER SHOULD BE EXEMPTED FOR HEALTH REASONS:	LIST ALLERGIES AND/OR DIETARY RESTICTIONS:
LIST CONDITIONS REQUIRING SPECIAL CONSIDERATION, ACCOMMODATIONS OR OF WHICH YOU WOULD LIKE TO MAKE THE CAMP AWARE:	LIST PAST TREATMENT THAT MAY AFFECT PARTICIPATION IN CAMP:
LIST SERIOUS INJURIES, DISEASES, OPERATIONS AND/OR ANY RESTRICTIONS ON PHYSICAL ACTIVITY:	LIST ANY MEDICATIONS CURRENTLY TAKING AND/OR MEDICAL DEVICES CARRIED ON THEIR PERSON, SUCH AS AN EPI-PEN OR INHALER: