RELEASE & HOLD HARMLESS, MEDICAL, PHOTOGRAPHY, & TRANSPORT CONSENT AGREEMENT

In order to participate in the program, the Parent/Guardian of a Minor must complete this form and submit it to the Program Director. Counselors must complete this form and submit it to the Program Director.

_____ **(Initials or N/A) For Parent/Guardian of Minor.** I am the Parent/Guardian of _____ _____("Participant") who is under eighteen years of age, and I am fully competent to sign this Agreement.

_____ **(Initials) For Parent/Guardian of Minor or Counselor.** I give permission for Participant to participate in _____(hereafter "the Program"). I acknowledge that the risk of injury from the activity involved in the Program is significant, including the potential for permanent disability and death, and while particular protective equipment and personal discipline will minimize this risk, the risk of serious injury does exist. I understand and appreciate the nature of such hazards and risks.

_____ **(Initials)** In consideration of Participant being permitted to participate in the Sports Program, I, on behalf of myself, my heirs, successors, and assigns, and as parent or legal guardian of Participant, **KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS,** both known and unknown, **EVEN IF ARISING FROM THE NEGLIGENCE** of **the Sports Program, The Citadel, the State of South Carolina, their respective officers, directors, agents, servants, employees, members, successors and assigns,** and I assume full responsibility for my child's participation in the program.

_____ **(Initials)** I, on behalf of myself, my heirs, successors, and assigns, and as parent or legal guardian of Participant, HEREBY **RELEASE** AND **HOLD HARMLESS the Program, The Citadel, the State of South Carolina, their respective officers, directors, agents, servants, employees, members, successors and assigns,** ("Releasees"), **WITH RESPECT TO ANY AND ALL INJURY, DISABILITY, DEATH**, or loss or damage to person or property, **WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES OR OTHERWISE,** that may result from or occur during Participant's participation in the Program.

_____ **(Initials)** I further agree to indemnify and hold harmless **The Citadel, the State of South Carolina, their respective officers, directors, agents, servants, employees, members, successors and assigns,** from liability for the injury or death of any person(s) and damage to property that may result from Participant's negligent or intentional act or omission while participating in **the Sports Program**.

_____ **(Initials) MEDICAL CONSENT**

1. **ROLE of PARTICIPANT at PROGRAM: [Check one.]**
   ☐ **Minor [Complete #2.]** ☐ **Counselor [Skip to #3.]**

2. **INFORMATION ABOUT MINOR'S PARENTS or GUARDIANS**
   Name of Parents/Guardians: _____ **Home Phone:** _____
   Mother's Day Phone: _____ **Mother's Mobile Phone:** _____
   Father's Day Phone: _____ **Father's Mobile Phone:** _____

3. **EMERGENCY CONTACT**

   I understand that I will be contacted as soon as possible in the event that my child will need medical attention. If I am not available, please contact:

   FIRST EMERGENCY CONTACT
   Name: _____ Home Phone: _____
   Work Phone: _____ Mobile Phone: _____

   SECOND EMERGENCY CONTACT
   Name: _____ Home Phone: _____
   Work Phone: _____ Mobile Phone: _____

4. **MEDICAL HISTORY (Fill out where applicable.)**

   A. **KNOWN MEDICAL, BEHAVIORAL, and PSYCHOLOGICAL CONDITIONS (Describe):**

   _____

   _____

   B. **ALLERGIES (Describe):**

   _____

   _____

   C. **PREVIOUS INJURIES (Include Dates):**

   _____

   _____

5. **MEDICATION**

   A. **REGULAR MEDICATION REQUIRED: [Check one.]** ☐ **YES** ☐ **NO**
   IF YES, LIST MEDICATION, DOSAGE, and TIME of DAY for TAKING

   - Medications will only be dispensed from the original pharmacy container labeled with the person's name, medicine name, dosage, and timing of consumption. A program official will dispense the medication. Please note that the Infirmary does not dispense medications except in the event of an emergency.
   - Over-the-counter medications must be provided in the manufacturer's container and labeled with the Minor's name, dosage, and timing of consumption.
   - The parent or guardian of a minor must provide written authorization before any medication can be dispensed to a Minor.

Medication	Dosage	Time(s) of Day for Taking

   B. **SPECIAL NEEDS for ACCOMMODATION at PROGRAM (Describe):** _____

   _____

   _____

_____ **(Initials)** **PHOTOGRAPHY CONSENT.** I authorize The Citadel and the Program to use any photographs or videos taken of the minor or counselor listed for publicity purposes. These photographs or videos may be posted to a web page, printed in newspapers/magazines, used in public displays, or used in some other appropriate manner to advertise this program.

_____ **(Initials) PERSONS AUTHORIZED TO PICK-UP & TRANSPORT MINOR TO/FROM PROGRAM.** The following person(s) is (are) authorized to pick-up & transport the minor to/from the program. There are no criminal, civil, legal, or other reasons precluding these persons from maintaining the safety of the minor. _____ _____

_____ **(Initials) I HAVE READ THIS RELEASE AND HOLD HARMLESS & CONSENT AGREEMENT, FULLY UNDERSTANDING ITS TERMS. I UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT. I SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.**

Participant's Printed Legal Name: _____

Parent's / Guardian's Printed Legal Name: _____

Signature of Parent / Guardian or Counselor: _____ Date: _____ (MM/DD/YYYY)

I also agree to follow all instructions and procedures of the program.
Participant's Signature: _____ Date: _____ (MM/DD/YYYY)

PHYSICIAN'S CERTIFICATION of PARTICIPANT'S HEALTH

*In order to participate in a **sports-related program**, the Physician of a Minor or Counselor in the Program must complete this form. The completed form must be returned to the Program Director. If a physical examination occurred within the last six months, then a copy of the results may be attached. Otherwise a physical examination must be conducted by a licensed healthcare practitioner within six months prior to the program. A physical examination is also required if the individual is currently under medical care, takes prescribed medication, requires a medically prescribed diet, has had an injury or illness during the last six months that limited activity foe a week or more, has ever lost consciousness during physical activity, or has suffered concussion from a head injury.*

Participant's Name: _____ Last 4 digits of SSN: _____

Note to Licensed Healthcare Practitioner: The person listed above will be participating in a program at The Citadel that may involve strenuous athletic outdoor activities, where the temperature may reach 95°F. Please review the healthcare history with this person for any interim changes. Please explain any abnormal evaluations. Thank you.

1. GENERAL HEALTH

Height: _____	Weight: _____	Blood Pressure: _____
Eyes: _____	Glasses/Contacts: _____	Hearing: _____
Teeth: _____	Braces: _____	Skin: _____
Heart: _____	Nose: _____	Throat: _____
Lungs: _____	Abdomen: _____	Hernia: _____
Posture (Spine): _____	Extremities: _____	Genitalia: _____

Allergies to Medications: _____

Other Allergies (Please specify type and severity): _____

_____

2. MEDICAL HISTORY

Does the individual have chronic medical problems, emotional difficulties, or behavioral issues of which you are aware? **[Check one.]** ☐ YES ☐ NO

If Yes, please describe the condition and list prescribed medications and dosing instructions.

_____

_____

_____

Recommendations and/or restrictions (e.g., diet, swimming, etc.):

_____

_____

_____

3. ACKNOWLEDGEMENT

I certify the veracity of the above information.

Printed Name of Examining Physician: _____
Address: _____
City, State, Zip: _____
Work Phone: _____ **Date:** _____

Signature of Examining Physician: _____