

Duke Volleyball Clinic
August 18, 2018 – Cameron Indoor Stadium
115 Whitford Drive, Durham, NC 27705

Clinic 9:00 AM – 10:30 AM (only open to 4th-8th graders)
Blue/White Scrimmage 10:30 AM – 12:30 PM

WAIVER AND RELEASE STATEMENT

The undersigned being a parent or legal guardian of the child requesting clinic admittance, does hereby affirm that the applicant is in good health, and suffers from no illness, disability or condition that requires the taking of medication on a regular basis unless that condition is disclosed and approved. Furthermore, the undersigned has no knowledge of any reason the applicant cannot participate in vigorous physical activity.

I understand that, as a participant in the clinic, the undersigned, on behalf of all parents and guardians, and on behalf of the applicant, hereby release the Duke Volleyball Clinic, Duke University, the Duke University Athletic Department, Jolene Nagel and all other employees or agents of the clinic from any liability from any loss or damage of personal property, injury or illness, mental or physical suffered by the camper during or related to camp.

MEDICAL TREATMENT CONSENT

I, the legal guardian of the below-named participant, authorize the Duke Volleyball staff to seek medical treatment for the participant as they see necessary at Duke University Medical Center or another nearby facility. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the participant's session. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide the program staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the below-named participant. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Volleyball staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Volleyball staff will notify me or my designee as soon as possible of any and all diagnoses and treatments.

Participant's Name: _____

Parent/Guardian's Signature: _____

Parent/Guardian's Contact Number: _____

Date: _____

Bring Signed to Clinic on August 18th