**Release and Medical Authorization**

Father Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (please print full legal name)

Camp Name\_\_Father/Son Camp\_\_\_\_\_\_\_ Date of Camp Operation\_\_\_\_\_\_\_

The release and treatment authorization must be signed by the participant.

**Release of Liability**

 In consideration of being permitted to participate in the Will Wade Basketball Camp, I do waive and release forever any and all rights for claims and damages I may have against the North Carolina State University, its governing board, officers, agents, employees, and Coach Will Wade, from and against any and all liability for any harm, injury, damage, claims, demands, actions, costs, and expenses of any nature which I may have or which may hereafter accrue to me, arising out of or related to any loss, damage, or personal injury, that may be sustained by me or by any property belonging to me while I am in, on, upon, or in transit to or from the premises where this Camp, or any adjunct to this Camp, occurs or is being conducted.

 I accept, understand, and assume that there is a risk of injury in this Camp, due to the physical nature of the sport, including, but not limited to, fall, contact with other participants, and being injured by thrown or batted balls. I agree to follow all instructions and to wear all necessary, recommended, and appropriate protective gear and equipment.

 I understand that this Camp is neither administered nor sponsored by the University and that Coach Will Wade is providing this instruction or camp outside the scope of his/her employment with the University. I agree to release, hold harmless, and indemnify the University, its governing board, its officers, its employees, its agents, and Coach Will Wade from any and all claims and liability arising out of the Camp.

**Medical and Surgical Authorization**

 I hereby authorize and give my consent to the health care providers to perform upon or administer to (father name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ any reasonable, necessary surgical or medical treatment. I also give permission to administer any anesthetic that may be necessary or advisable during the medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections, and minor operations and procedures. In the case of psychiatric and/or psychological emergencies involving psychological treatment, parental authorization for treatment beyond that responsive to the emergency will be requested.

 I understand that the Will Wade Basketball Camp, LLC does not offer an excess insurance for injuries sustained as a result of camp participation. I authorize my insurance company to pay benefits to the health care providers that the Sports Camp employees send my son or daughter to for evaluation and treatment. I authorize the disclosure of medical information to my insurance company for the purpose of a claim.

 This permission is good only while the student is attending the Will Wade Basketball Camp and only until the student has attained his/her eighteenth birthday.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Father/Guardian’s Signature Date

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father/Guardian Print or Type

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Co. Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_