ACKNOWLEDGMENT, WAIVER, RELEASE AND INDEMNIFICATION AGREEMENT

The undersigned, who intends to take the Red Storm Baseball camp at The Ballpark at St John's located at St. John's University, New York (the "University"), hereby acknowledges that the Red Storm Baseball camps are not sponsored by the University, and are being provided solely by Ed Blankmeyer Inc/Head baseball Coach on the University's premises. I hereby acknowledge and accept that there are certain risks arising from or in connection with the Red Strom Baseball Camps, including but not limited to bodily injury. I am fully aware of the risks and hazards connected with the activity, and voluntarily assume full responsibility for any risks of loss, property damage or personal injury that may be sustained by me as a result of my taking Red Storm Baseball Camps, whether caused by the negligence of the University or otherwise.

I hereby represent and warrant that I am in good health and that I have no health condition, illness or communicable disease that may make my use of the Ballpark at St John's injurious to me or any other user of The Ballpark at St John's. If I should develop any such condition, illness or disease during the term of the Red Storm Baseball camps, I promise to discontinue the Red Storm Baseball camps until I have received an appropriate medical release from my doctor authorizing me to continue the Red Storm Baseball camps.

I hereby release and forever discharge the University and its trustees, officers, servants, agents and employees from any and all liability for any damages, losses or injuries which may be sustained or suffered by myself arising out of, during or in connection with the Red Storm Baseball Camps.

I hereby hold harmless the University and its trustees, officers, servants agents and employees from any and all liability, loss or damage they or any of them incur or sustain as a result of any claims, demands, judgments, costs or expenses, including attorneys' fees, which may result from, arise out of, or relate to the Red Storm Baseball Camps.

I further represent and warrant that my participation in the Red Storm Baseball Camps is covered by a policy of comprehensive health and accident insurance that provides coverage for injuries that I may sustain as part of my participation in the Red Storm Baseball Camps.

_____ _____

Date Signature of Participant

I, _____,

(A) am the parent or legal guardian of the above participant,

(B) have read the foregoing Acknowledgment, Waiver, Release and Indemnification Agreement (including such parts as may subject me to personal financial responsibility),

(C) am and will be legally responsible for the obligations and acts of the participant as described in this Acknowledgment, Waiver, Release and Indemnification Agreement, and

(D) agree, for myself and for the participant, to be bound by its terms.

_____

Signature of Parent/Guardian

_____

Date

HEALTH RECORD FOR CHILDREN IN DAY CAMPS, AFTERSCHOOL & YOUTH CENTERS

(This side to be filled out by parent before presentation to physician)

NAME OF PROGRAM_____

CHILDS LAST NAME _____ FIRST NAME _____ BIRTHDATE _____ SEX _____

Home Address: _____ Phone:_____

Parent or Guardian_____ Phone:_____

Place of Employment: Father (Guardian)_____ Phone:_____
Mother (Guardian)_____ Phone:_____

In case of an emergency, notify:_____ Phone:_____

If parent, Guardian are not available in an emergency, notify:
1- _____ Phone:_____
2- _____ Phone:_____

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:
Yes_____ No_____ (If yes, state type of exposure) _____

HEALTH HISTORY: (check, giving approximate dates)

	Allergies	**Diseases**
Ear Infection_____	Hay Fever_____	Chicken Pox_____
Rheumatic Fever_____	Ivy Poisoning, etc._____	Measles_____
Convulsion_____	Insect Stings_____	German Measles_
Diabetes_____	Penicillin_____	Mumps_____
Behavior_____	Other Drugs_____	Other Contagious Illness_____
Asthma_____		

Other Past Illnesses_____
Operations or Serious Injuries (Dates)_____
Chronic or Recurring Illness_____
Any specific activities to be encouraged_____
Conditions that require activity to be restricted?_____
Permission for all program activities unless otherwise noted by Dr._____
Appliance Worn (glasses, contacts, etc.)_____
Medication taken_____
Suggestion from Parent/Guardian_____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program Staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship_____ Signature_____ Date_____ Phone_____

Department of Health

PHYSICAL EXAMINATION

(To be filled out by physician – please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child in Day Camps and Afterschool and Youth Center programs.

IMMUNIZATION HISTORY – This is a record of dates of basic immunization and most recent booster doses.

DpaP, DTP or TD Date_____ Date_____ Date_____ Date_____ Date_____
Polio Date_____ Date_____ Date_____ Date_____ Date_____
MMR Date_____ Date_____
Hemophilus Influenzae type b Date_____ Date_____ Date_____ Date_____
Hepatitis B Date_____ Date_____ Date_____
Varicella Date_____ Date_____
Other_____ Date_____ Date_____

MEDICAL EXAMINATION – to be filled out by licensed physician.

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

Code: S = Satisfactory
X = Not Satisfactory (Explain)
O = Not Examined

General Appearance_____
Height_____ Weight_____ Blood Pressure_____ Hgb. Test (Date)_____
Urinalysis (Date) _____ Posture & Spine_____ Throat – Tonsils_____
Eyes_____ Vision_____ w/Glasses_____ Extremities_____ Heart_____
Ears_____ Hearing_____ Feet_____ Lungs_____ Skin_____
Nose_____ Teeth_____ Abdomen_____ Hernia_____
Genitalia_____
Neurological Findings_____
Describe Abnormal Findings and/or Handicapping Conditions_____
Has child ever received products containing horse serum?_____
Allergy: (*Please Specify*)_____
Recommendations and restrictions while in camp.
Special Diet_____
Special Medicine (name it)_____
Is parent/guardian sending special medicine?_____
Swimming_____ Diving_____
Activity Restrictions_____

General Appraisal:_____

I have examined the person here in described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.

_____M.D.
EXAMINING PHYSICIAN (SIGNATURE)

_____
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone_____ Address_____

Date of Examination_____ _____
ZIP CODE