

Alabama ODP  
Region Camp Player Information Packet

**BOYS**



Please complete in its entirety and submit via email to [asaboysodp@gmail.com](mailto:asaboysodp@gmail.com)

Subject: AGE GROUP, GENDER - Last Name, First Name

AGE GROUP/GENDER:	
LAST NAME, FIRST NAME:	



## PARENT/GUARDIAN CONSENT AND PLAYER MEDICAL RELEASE FORM

Player's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### **EMERGENCY INFORMATION**

Father's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### **In an emergency, when parents cannot be reached, please contact:**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Other Medical Conditions: \_\_\_\_\_

Player's Physician: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Medical and/or Hospital Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

### **PLEASE COPY BOTH SIDES OF YOUR HEALTH INSURANCE CARD AND ATTACH TO THIS FORM**

### **PARENT/GUARDIAN CONSENT AND MEDICAL RELEASE**

Recognizing the possibility of injury or illness, and in consideration for US Youth Soccer and members of US Youth Soccer accepting my son/daughter as a player in the soccer programs and activities of US Youth Soccer and its members (the "Programs"), I consent to my son/daughter participating in the Programs. Further, I hereby release, discharge, and otherwise indemnify US Youth Soccer, its member organizations and sponsors, their employees, associated personnel, and volunteers, including the owner of fields and facilities utilized for the Programs, against any claim by or on behalf of my player son/daughter as a result of my son's/daughter's participation in the Programs and/or being transported to or from the Programs. I hereby authorize the transportation of my son/daughter to or from the Programs.

My player son/daughter has received a physical examination by a licensed medical doctor and has been found physically capable of participating in the sport of soccer. I have provided written notice, which is submitted in conjunction with this release and attached hereto, setting forth any specific issue, condition, or ailment, in addition to what is specified above, that my child has or that may impact my child's participation in the Programs. I give my consent to have an athletic trainer and/or licensed medical doctor or dentist provide my son/daughter with medical assistance and/or treatment and agree to be financially responsible for the reasonable cost of any such assistance and/or treatment.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



### **Participants Agreement to Accept and Abide by Rules of the Program**

Players, coaches and chaperones participating in the Olympic Development Program with US Youth Soccer are exercising a privilege afforded them by US Youth Soccer in pursuit of Regional and National recognition as youth soccer players. These players must exhibit the maturity to be successful in this pursuit. Thus, the following guidelines and rules shall apply in all activities within the Olympic Development Program.

#### **I. GENERAL GUIDELINES:**

Participants are expected to conduct themselves at all times in a manner which is in keeping with representing US Youth Soccer and will not bring discredit upon the Association.

When traveling with the ODP Program, each participant is expected to dress appropriately as befits representing US Youth Soccer or as directed by the Coach.

Respect for property of others, adherence to the rules and guidelines as specified here or by the Coach/Administrator and observance of State and Federal laws are required for participation in this program.

#### **II. DISCIPLINE RULES:**

1. Substance use and/or possession thereof [drugs, alcohol, or, in the case of minors, tobacco] is cause for immediate dismissal from the program.
2. Persistent irresponsible and disrespectful behavior is cause for dismissal from the program.
3. Destruction of property or violation of State and Federal laws is cause for dismissal from the program.
4. Zero Tolerance on Hazing: defined as any activity that endangers the physical safety of another person, or produces mental or physical discomfort; causes embarrassment, fright, humiliation, or ridicule; or degrades the individual is cause for dismissal from the program and other programs of US Youth Soccer.
5. Failure to comply with any and all camp or team rules (curfew, attendance, dress code, schedules, etc.) may be cause for disciplinary action. Persistent failure will be cause for dismissal from the program for the remainder of the current season of this program and could affect a player's future participation.

**NOTE:** If dismissal from the program or an event occurs while traveling, the participant may be sent home immediately at the participant's cost by whatever means is most convenient for the Program Administrators. No reimbursement of program fees will be made to the dismissed participant or the participant's family.

**We, the undersigned, have read, understand and agree to abide by the above guidelines and rules. We also agree to accept actions taken for failure to abide by these guidelines and rules.**

\_\_\_\_\_  
(Please Print Participant's Name)

\_\_\_\_\_  
(Please Print Parent's or Legal Guardian's Name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date



Copy of both sides of your Insurance Card here:



**OLYMPIC DEVELOPMENT PROGRAM  
MEDICAL HISTORY QUESTIONNAIRE**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SEX \_\_\_\_ M \_\_\_\_ F

EMERGENCY CONTACT \_\_\_\_\_ HM PH (\_\_\_\_) \_\_\_\_\_ WK PH (\_\_\_\_) \_\_\_\_\_

PLEASE CIRCLE EITHER "YES" OR "NO" TO ALL QUESTIONS AND PROVIDE ADDITIONAL DETAILS WHERE REQUESTED. YOU MAY PUT DETAILS ON THE BACK OF THIS FORM IF NEEDED. ALL INFORMATION IS CONFIDENTIAL.

- 1) ARE YOU ALLERGIC TO ANY MEDICATION (ASPIRIN, PENICILLIN, SULFA, ETC)? **YES NO** (LIST) \_\_\_\_\_
- 2) DO YOU TAKE ANY PRESCRIBED MEDICATION ON A PERMANENT BASIS OR SEMI-PERMANENT BASIS (STEROIDS, BIRTH CONTROL PILLS, ANTI-INFLAMMATORIES, ANTIBIOTICS, ETC)? **YES NO** (LIST & GIVE REASON) \_\_\_\_\_
- 3) HAVE YOU EVER HAD ANY EPILEPTIC SEIZURE? **YES NO**
- 4) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE EPILEPSY? **YES NO** (LIST MEDICATION) \_\_\_\_\_
- 5) HAVE YOU EVER BEEN TREATED FOR DIABETES? **YES NO**
- 6) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU WERE ANEMIC? **YES NO** WHEN? \_\_\_\_\_
- 7) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE SICKLE CELL ANEMIA? **YES NO**
- 8) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE SICKLE CELL TRAIT? **YES NO** \_\_\_\_\_
- 9) DO YOU HAVE OR HAVE YOU EVER HAD HIGH BLOOD PRESSURE? **YES NO** (LIST MEDICATION) \_\_\_\_\_
- 10) DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING DISEASES?  
 HEART DISEASE (HEART MURMUR, RHEUMATIC FEVER) **YES NO** (GIVE DATE) \_\_\_\_\_  
 LUNG DISEASE (PNEUMONIA) **YES NO** (GIVE DATE) \_\_\_\_\_  
 KIDNEY DISEASE (INFECTIOUS) **YES NO** (GIVE DATE) \_\_\_\_\_  
 LIVER DISEASE (MONONUCLEOSIS, HEPATITIS) **YES NO** (GIVE DATE) \_\_\_\_\_
- 11) DO YOU HAVE OR HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE ASTHMA? **YES NO** (LIST MEDICATION) \_\_\_\_\_
- 12) DO YOU HAVE OR HAVE YOU EVER HAD A HERNIA OR "RUPTURE"? **YES NO** HAS IT BEEN REPAIRED? \_\_\_\_\_ DATE \_\_\_\_\_
- 13) HAVE YOU EVER BEEN "KNOCKED OUT"(UNCONSCIOUS) IN THE PAST 3 YEARS? **YES NO** (LIST DATES) \_\_\_\_\_
- 14) HAVE YOU EVER HAD A CONCUSSION OR OTHER HEAD INJURY IN THE PAST 3 YEARS? **YES NO** (LIST DATES) \_\_\_\_\_
- 15) HAVE YOU STAYED OVERNIGHT IN THE HOSPITAL DUE TO A HEAD INJURY? **YES NO** (LIST DATES) \_\_\_\_\_
- 16) HAVE YOU EVER HAD A NECK INJURY INVOLVING BONES, NERVES, OR DISKS THAT DISABLED YOU FOR A WEEK OR LONGER?  
**YES NO** TYPE OF INJURY \_\_\_\_\_ DATES \_\_\_\_\_
- 17) DO YOU WEAR GLASSES OR CONTACTS DURING COMPETITION? **YES NO**
- 18) DO YOU WEAR ANY OF THE FOLLOWING DENTAL APPLIANCES? **YES NO** (CIRCLE THOSE WHICH APPLY) PERMANENT BRIDGE, BRACES, REMOVABLE RETAINER, PERMANENT RETAINER, REMOVABLE PARTIAL PLATE, FULL PLATE, PERMANENT CROWN OR JACKET?
- 19) HAVE YOU HAD A BROKEN BONE OR FRACTURE IN THE PAST 2 YEARS? **YES NO** \_\_\_\_ RIGHT OR \_\_\_\_ LEFT  
 WHAT BONE(S) \_\_\_\_\_ DATES \_\_\_\_\_
- 20) HAVE YOU EVER HAD A SHOULDER INJURY IN THE PAST 2 YEARS THAT DISABLED YOU FOR A WEEK OR LONGER? (DISLOCATION, SEPARATION, ETC) **YES NO** \_\_\_\_ RIGHT OR \_\_\_\_ LEFT TYPE OF INJURY \_\_\_\_\_ DATE \_\_\_\_\_
- 21) HAVE YOU EVER HAD SHOULDER SURGERY? **YES NO** \_\_\_\_ RIGHT OR \_\_\_\_ LEFT DATE \_\_\_\_\_  
 WHAT WAS DONE AND WHY? \_\_\_\_\_
- 22) HAVE YOU EVER INJURED YOUR BACK? **YES NO** TYPE OF INJURY \_\_\_\_\_ DATE \_\_\_\_\_
- 23) DO YOU HAVE BACK PAIN? **YES NO** (CIRCLE THOSE THAT APPLY) SELDOM, OCCASIONALLY, FREQUENTLY, WITH VIGOROUS EXERCISE, WITH HEAVY LIFTING
- 24) HAVE YOU INJURED YOUR KNEE IN THE PAST 2 YEARS? **YES NO** \_\_\_\_ RIGHT OR \_\_\_\_ LEFT DATE \_\_\_\_\_
- 25) HAVE YOU BEEN TOLD BY A DOCTOR OR ATHLETIC TRAINER THAT YOU INJURED THE CARTILAGE IN YOUR KNEE? **YES NO**  
 \_\_\_\_ RIGHT OR \_\_\_\_ LEFT DATE \_\_\_\_\_
- 26) HAVE YOU BEEN TOLD BY A DOCTOR OR ATHLETIC TRAINER THAT YOU INJURED THE LIGAMENTS IN YOUR KNEE? **YES NO**  
 \_\_\_\_ RIGHT OR \_\_\_\_ LEFT DATE \_\_\_\_\_
- 27) HAVE YOU HAD KNEE SURGERY? **YES NO** \_\_\_\_ RIGHT OR \_\_\_\_ LEFT WHAT WAS DONE? \_\_\_\_\_ DATE \_\_\_\_\_
- 28) HAVE YOU HAD A SEVERE ANKLE SPRAIN IN THE PAST 2 YEARS? **YES NO** \_\_\_\_ RIGHT OR \_\_\_\_ LEFT DATE \_\_\_\_\_
- 29) DO YOU HAVE A PIN, SCREW, OR PLATE IN YOUR BODY? **YES NO** LOCATED WHERE \_\_\_\_\_ DATE \_\_\_\_\_
- 30) DO YOU HAVE OTHER CONDITIONS THAT WE SHOULD BE AWARE OF (I.E. ULCERS, PREGNANCY, FOOD OR INSECT ALLERGIES, TENDINITIS, ETC)? **YES NO** (SPECIFY & GIVE DETAILS) \_\_\_\_\_
- 31) DATE OF LAST IMMUNIZATION: \_\_\_\_ TETANUS \_\_\_\_ POLIO \_\_\_\_ MUMPS \_\_\_\_ RUBELLA \_\_\_\_ MEASLES

**THE QUESTIONS ON THIS FORM HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.**

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ATHLETE'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



**OLYMPIC DEVELOPMENT PROGRAM  
PLAYER DATA FORM**

**PERSONAL INFORMATION**

DATE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_ - \_\_\_\_ - \_\_\_\_ GENDER \_\_\_M \_\_\_F  
(MO) (DAY) (YR)

NAME \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE INITIAL)

STREET ADDRESS \_\_\_\_\_

PO BOX \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PARENT NAME (S) \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ PLAYER'S CELL PHONE (\_\_\_\_) \_\_\_\_\_

DAD'S WORK PHONE (\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_

MOM'S WORK PHONE (\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_

PREFERRED EMAIL \_\_\_\_\_

NAME OF SCHOOL PRESENTLY ATTENDING \_\_\_\_\_

YEAR OF HIGH SCHOOL GRADUATION \_\_\_\_\_ GRADE POINT AVERAGE \_\_\_\_\_

TEST SCORES PSAT \_\_\_\_\_ PACT \_\_\_\_\_ SAT \_\_\_\_\_ ACT \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SHIRT SIZE \_\_\_\_\_ SHORT SIZE \_\_\_\_\_

CLUB TEAM \_\_\_\_\_

CLUB COACH'S NAME \_\_\_\_\_ PHONE NUMBER (\_\_\_\_) \_\_\_\_\_

PRIMARY POSITION (PLEASE LIST AT LEAST ONE SPECIFIC POSITION) \_\_\_\_\_

ARE YOU A US CITIZEN? YES \_\_\_ NO \_\_\_ (IF NO) CITIZEN OF \_\_\_\_\_

DO YOU HAVE A VALID & CURRENT PASSPORT? YES \_\_\_ NO \_\_\_ COUNTRY \_\_\_\_\_

PASSPORT NUMBER \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_

**(ATTACH A LEGIBLE PHOTOCOPY OF YOUR PASSPORT TO THIS FORM)**

PLEASE LIST THE NAME OF THE MAJOR AIRPORT NEAREST YOUR HOME THAT YOU WILL WANT TO DEPART FROM FOR REGION III EVENTS \_\_\_\_\_

# Youth Program Medication Management Form

## Instructions

Prescription or over-the-counter (OTC) medications, including medications for conditions such as food, drug or insect allergies; diabetes; asthma; or epilepsy may be brought to the Program under the condition that the medications will be secured by program staff and made available to participant for self-administration as authorized in writing by the participant's parent/guardian. It is the participant's responsibility to come to get their medications, but program staff will make every effort to remind them as needed. If the participant is unsure of the medication to take or the correct dosage, program staff will contact the parent or guardian for clarification.

Medication must be in its original container and all labels must be intact with instructions clearly legible. Prescription medications must be labeled by the pharmacist or prescriber, with the name, address and phone number for pharmacist or prescriber. It is advised that containers hold only the amount required for the time the participant will be attending the Program. If a tablet should be cut in half, this should be done before the submitting medication to the Program. Please send medicine cups for liquid medications.

All medications for a single participant should be stored in a plastic bag labeled with the participant's name and date of birth. All medications and medication bags will be returned to the participant's parent/guardian when the program is over.

This form must be completed fully in order for participants to self-administer required prescription or OTC medication. A new Medication Management form is required for each program attended by the participant, each medication, and each time there is a change in dosage or time of administration of a medication.

*Note: Unless we have prior parental authorization, we cannot provide ANY OTC medications.*

# Youth Program Medication Management Form

Participant Name: \_\_\_\_\_

Program/Activity Name: \_\_\_\_\_ Program Date: \_\_\_\_\_

## Medication Information

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Condition for which medication is being administered: \_\_\_\_\_

Specific Directions (e.g., on empty stomach/with water, taken with food, etc.): \_\_\_\_\_

Time/frequency of administration: \_\_\_\_\_

If taken as needed, frequency: \_\_\_\_\_

If taken as needed, for what symptoms: \_\_\_\_\_

Relevant side effects: \_\_\_\_\_

Medication shall be administered from (date): \_\_\_\_\_ to \_\_\_\_\_

### *Special Storage Requirements:*

Is refrigeration required?     Yes     No

Prescriber's Name/Title: \_\_\_\_\_

Prescriber's Place of Employment: \_\_\_\_\_ Telephone: \_\_\_\_\_

If your child requires any assistance with their medications, please explain: \_\_\_\_\_

## Authorization

- I authorize and recommend self-administration by my child for the above medication.  
(Please initial: \_\_\_\_\_)
- I also affirm that they have been instructed in the proper self-administration of the prescribed medication by their attending physician. (Please initial: \_\_\_\_\_)
- I shall indemnify and hold harmless the Program Staff, The University of Alabama, its Board of Trustees, Administration, Faculty, Staff, Student Leaders, and all other officers, directors, employees and agents against any claims that may arise relating to my child's self-administration of prescribed medication(s).  
(Please initial: \_\_\_\_\_)

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_



## Youth Protection Program: Liability Waiver

Program: \_\_\_\_\_ Event Date(s): \_\_\_\_\_

Participant: \_\_\_\_\_ Age (at the time of program): \_\_\_\_\_

### Purpose

This form is to be signed by each Participant (or the parent/guardian of any Participant under the age of 19) involved in the Program. In consideration for the educational, social, recreational, and other benefits to be provided, the receipt and adequacy of which is acknowledged, Participant agrees as follows.

### Liability Release

**THIS IS A RELEASE OF LIABILITY.** Participant knowingly and voluntarily waives, releases, exculpates, and discharges UA and \_\_\_\_\_ from and against any and all Potential Liabilities connected with the Program. By signing this form, the Participant voluntarily agrees to discharge UA, \_\_\_\_\_, and any third party entities or contractors in advance from all such Potential Liabilities.

### Indemnification

The Participant agrees to hold harmless and indemnify UA and \_\_\_\_\_ from and against Potential Liabilities related to or arising from Participant's involvement in the Program.

### Assumption of Risk

The Participant understands and acknowledges that there are risks, including significant risks, inherent in all activities that can result in loss, damages, injury, or death, including, without limitation:

- **Travel/traffic risks** such as accidents, crashes, and risks from autos operated by UA or \_\_\_\_\_ as well as autos operated by other individuals or entities, poorly maintained roads, sidewalks, as well as criminal acts that can result in serious injury or death;
- **Premises risks**, including those that may be owned by others and risks from water, such as drowning;
- **Injury risks** from falls, collisions, or accidents (such as cuts, bruises, torn muscles, sprains, broken bones, concussion, etc.);
- **Outdoor risks**, such as weather, lightning, heat or cold, insect bites/stings, allergic reactions to plants, dehydration, hypothermia, drowning, sunburn, animals, and limited access to medical care;
- **Risks from others** involved in the Program such as transmitted illnesses or others' actions;
- **Health risks**, such as allergic reactions, heart or respiratory events as well as other risks inherent in any strenuous activities, including things identified as "injury risks" herein;
- **Equipment risks**, including failure, misuse, inherent risks, and risks from UA or non-UA equipment;
- **Other risks and hazards** beyond the control of UA \_\_\_\_\_, including criminal acts that can result in serious injury or death.

Activities potentially related to the Program including but not limited to:

The Participant acknowledges that they have had an opportunity to investigate the Program before executing this form and, knowing and understanding all risks associated with the Program, Participant nevertheless **VOLUNTARILY AGREES TO ASSUME AND ACCEPT ALL RISKS** that potentially accompany participation in the Program. Participant also agrees to take all reasonable steps to avoid any risks, injury, or death.

## Health Care and Emergencies

Neither UA nor \_\_\_\_\_ accepts responsibility or liability for providing health care services or health care insurance for Participant. Participant should consult his/her own medical care provider, and warrants his/her physical fitness to participate in the Program. Participant authorizes UA and \_\_\_\_\_ to obtain any necessary medical treatment for Participant during the Program. Participant agrees to be responsible for the payment of any fees and charges that may be imposed by any doctor or hospital facility in the provision of medical care to Participant. Further, Participant agrees to indemnify and hold UA and \_\_\_\_\_ harmless from any claim that may be made by a doctor of medical facility of said fees and charges incurred in the provision of medical care to Participant. The Participant is required to provide the name(s) and contact number(s) for a parent, guardian, or other party that is a reliable contact in the event of emergencies.

## Conduct

Participant agrees, for the duration of the Program, to abide by all applicable federal, state, and local laws as well as the rules and regulations for the Program. Participant also agrees to follow posted signs as well as instructions and directions of University officials and Program directors and supervisory staff.

## Photography

Participant acknowledges that photographs and possible videos may be taken and irrevocably and perpetually authorizes UA and \_\_\_\_\_ to broadcast these images. Participant releases and discharges UA and \_\_\_\_\_ from any potential claims related to the broadcast or use of their image, and any potential claims related to the work. Participant waives any right to inspect or approve the work or the broadcast of their image. This agreement shall be interpreted in accordance with applicable law. This is the entire agreement of the parties, and any changes must be in writing.

## Definitions

The following terms have the stated meaning when used in this document:

- **Applicable Law** – the laws of the State of Alabama, without regard to conflicts of laws provisions. UA does not waive, but reserves, all immunities, including Article I, section 14, of the Alabama Constitution. Claims against the University must be made to the State Board of Adjustment. To the extent not barred by immunity, nor required to be filed before the Board of Adjustment, exclusive venue and jurisdiction of all disputes shall lie in the state and federal courts of Tuscaloosa County, Alabama.
- **Broadcast** - to use, reuse, broadcast, publish and/or copyright, in whole or in part, for advertising, promotion, publicity, trade, educational, commercial, merchandising, packaging, public relations and media purposes, in all media, worldwide without limitation, in perpetuity.
- **Image** - image, picture, name, biographical information, voice, statements, recordings or interviews made by or attributable to the person who is appearing in the work, verbatim or otherwise, photographic portraits, drawings, visual representations, video tapes, motions pictures, or other use of likeness in whole or in part, and any reproductions thereof.
- **Participant** – the person participating in the Program or any University employee (regular or temporary), 3<sup>rd</sup> party employee, student, or volunteer working in any capacity to facilitate or support the Program. If

the Participant is under age 19 or is under some form of court-ordered guardianship or custodial arrangement, permission and acknowledgement by a parent/guardian is required.

- **Potential Liabilities or Claims** – any and all loss, injury, death, claims, actions, suits, proceedings, settlements, damages, costs, fees, and expenses, at law or equity, known and unknown, foreseen and unforeseen, including, but not limited to, attorney fees and costs of litigation, and liabilities arising out of, connected with, or resulting from the Participant’s involvement in the Program, such as medical expenses, other costs, injury, sickness, or death. Additionally, potential claims related to the use of the Participant’s image may refer to any liability, damages (compensatory or punitive), claims, or causes of action whatsoever, including, without limitation, claims for invasion of privacy, defamation of character or any alteration, distortion or illusionary effect, whether intentional or otherwise.
- **Program** – \_\_\_\_\_ including all activities incidental or connected therewith, such as housing, dining, training, activities, and transportation. Programs may be held on or off University property and may require transit between two or more locations. The terms of this document will apply regardless of Program location, including to and from the event(s).
- **UA** – The Board of Trustees of The University of Alabama (hereinafter referred to as “UA” or “University”), including The University of Alabama, affiliated foundations, and their respective trustees, officers, employees, agents, representatives and volunteers.
- **Work** – the finished product and any material used in connection therewith.
- \_\_\_\_\_ - \_\_\_\_\_ and their directors, trustees, officers, employees, agents, representatives, and volunteers.

## Emergency Contact(s):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## Acknowledgement

I, AS PARTICIPANT, ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS ENTIRE DOCUMENT AND, RELYING WHOLLY UPON MY OWN JUDGMENT, BELIEF, AND KNOWLEDGE THE RISKS ASSOCIATED WITH THE PROGRAM, WHICH INCLUDE SIGNIFICANT INJURY OR DEATH, VOLUNTARILY AGREE TO EXECUTE THIS DOCUMENT AND PARTICIPATE IN THE PROGRAM. I ACKNOWLEDGE THAT NO ORAL REPRESENTATIONS, STATEMENTS, OR INDUCEMENTS HAVE BEEN MADE TO ME SEPARATE AND APART FROM THE TERMS OF THIS DOCUMENT. I VOLUNTARILY SIGN THIS AGREEMENT OF MY OWN FREE WILL FULLY INTENDING TO LEGALLY BIND MYSELF, MY HEIRS, SUCCESSORS, AND ASSIGNS TO ITS TERMS.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Phone: \_\_\_\_\_

\*If Participant is under the age of 19, a Parent/Guardian must execute this document.

## Parent/Guardian Acknowledgement

THE SIGNING PARENT/GUARDIAN CERTIFIES THAT THEY ARE OVER THE AGE OF 19, HAS READ AND UNDERSTANDS THIS DOCUMENT, UNDERSTANDS THE RISKS, INCLUDING INJURY OR DEATH, ASSOCIATED WITH THE PROGRAM, IS VOLUNTARILY ALLOWING PARTICIPANT TO TAKE PART IN THE PROGRAM, HAS THE RIGHT TO SIGN ON BEHALF OF THE PARTICIPANT, IS SIGNING THIS DOCUMENT VOLUNTARILY, ACKNOWLEDGES THAT NO ORAL REPRESENTATIONS, STATEMENTS, OR INDUCEMENTS HAVE BEEN MADE SEPARATE AND APART FROM THE TERMS OF THIS DOCUMENT, AND AGREES TO ENTER INTO THE SAME, FULLY INTENDING TO LEGALLY BIND PARTICIPANT, HIS/HER HEIRS, SUCCESSORS, AND ASSIGNS TO THE TERMS OF THIS DOCUMENT.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship: \_\_\_\_\_