

# Carnegie Mellon University

## ASSUMPTION OF RISK & GENERAL RELEASE

I want my child to participate in the Carnegie Mellon 2012 \_\_\_\_\_ Camp ("Camp"). My child has been examined by a physician and determined to be able to participate in Camp activities. I understand that Camp activities are physically strenuous and that there are hazards and risks, as well as benefits, associated with participation in the Camp. I voluntarily assume all the hazards and risks on behalf of my child. In consideration of the benefits, I, on behalf of myself, my child, and those acting on our behalf, irrevocably and unconditionally release, waive, and promise not to sue Carnegie Mellon and those acting on its behalf, from/for any and all liabilities, losses, injuries, damages, claims, actions and causes of action arising from or connected with his/her participation in the Camp including but not limited to, transportation, and the securing of medical treatment. I give Carnegie Mellon permission to provide/secure medical treatment for my child in a situation requiring medical treatment in Carnegie Mellon's judgment.

I grant Carnegie Mellon (and/or those acting on its behalf) permission to photograph, videotape, or record my child's image, voice and/or name in connection with the Program and to use the resulting materials in university or other publications, web sites, CDs, DVDs and/or other media, for educational and promotional purposes. I hereby waive and release any rights that I or s/he may have in said materials.

The laws of Pennsylvania shall apply to this release. If any of its provisions are declared illegal, unenforceable, or ineffective, they shall be deemed severable, and all other provisions shall remain valid and binding. I'm an adult (18 years old or older), competent to sign this release. I've read it, understand its contents, and intend to be legally bound by it.

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

\_\_\_\_\_  
Date

PARTICIPANT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

EMERGENCY CONTACT:  
Name: \_\_\_\_\_

INSURANCE:  
Insurance Company: \_\_\_\_\_

Relationship: \_\_\_\_\_

Policy/Group #: \_\_\_\_\_

Phone (w): \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Phone (c): \_\_\_\_\_

Physician Phone: \_\_\_\_\_

ALLERGIES & MEDICATIONS – Please list current allergies and medications we should be aware of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_