2009 BUFFALO SWIM CAMPS APPLICATION

Last Name: _____

First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Age: _____

Emergency Phone: _____ Entering grade _____ in Fall '09

E-mail Address: _____

Name of Coach (if any): _____

Roommate Preference: _____ T-shirt size: _____

[t-shirts available in adult sizes only]

Please indicate the camp(s) you are registering for:

UB SWIM CAMP

June 28 - July 2, 2009

☐ Overnight Camper: $475 ☐ Commuter Camper: $275

Overnight campers are required to send a separate check in the amount of $35 for the room key security deposit. This check will be returned following room check-out when the key is returned.

The first 100 campers will be guaranteed a spot in camp.

*Total enclosed $ _____

**A $10 service charge will be assessed for all returned checks.*

** A full refund, less $50 administration fees, will be provided if a registered camper withdraws from the UB Swim Camp.*

I hereby request that my child be admitted to the UB Swim Camp and authorize the directors or any member of the staff to act for me according to their best judgement in any emergency requiring medical attention for which I will pay all costs. I understand that any camper who does not abide by the rules and regulations of the camp is subject to dismissal without reimbursement or recourse.

_____ _____

Parent/Guardian signature Date

2009 BUFFALO SWIM CAMPS

Register online at **www.ubcamps.com**
or mail application, payment and completed medical form to:

University at Buffalo Swim Camp
University at Buffalo
121 Fargo Building • Buffalo, New York • 14261

The deadline for application submission is June 22, 2009.

WAIVER FORM RELEASE FOR MEDICAL TREATMENT

Please complete this application carefully and fill out all of the information. Your admittance to the camp may be delayed if the information is incomplete.

Name: _____

Date of Birth: _____ Sex: _____ Age: _____

Health History: *Please list ANY allergies, disease, medications, special needs, restrictions and/or limitations. Please include a separate sheet if you need more space.* _____

_____

_____

_____

_____

List date(s) of immunization against the following:

_____ Diphtheria

_____ Haemophilus Influenza Type B

_____ Measles

_____ Mumps

_____ Poliomyelitis

_____ Rubella

_____ Tetanus

_____ Varicella

Family Physician's Name: _____

Physician's Phone Numbers: _____ (Day) _____ (Evening)

Parent/Guardian Health Insurance Company: _____

Policy Number: _____

Address: _____

Parent/Guardian Authorization:
This health history is correct to the best of my knowledge, and the person herein as described has permission to participate in all camp activities except as listed above. In the event that I can not be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for and order injection, anesthesia, or surgery for my child as named above.

My son/daughter has had a physical recently and may participate in all activities at the UB Camp. I give permission for my son/daughter to be treated by a certified athletic trainer or licensed physician. I further agree that the UB Camp staff should be held harmless from and indemnified against any and all liability, cost claims, loss or damage which it or they may incur as a result of an accident or injury to my child.

_____

Parent/Guardian Signature (Required) Date

Please note: NCAA rules prohibit representative of UB's athletics interests (a booster) who is not naturally or legally responsible for a prospective student-athlete (grades 9-12) from providing any expenses to attend a camp or clinic. Violations of this could result in loss of NCAA eligibility for the prospective student-athlete. If you have questions regarding this or any other NCAA rule, please contact the UB Office of Compliance at (716) 645-3146.

EMT AND CERTIFIED ATHLETIC TRAINERS WILL BE AVAILABLE AT ALL TIMES