

**RELEASE OF LIABILITY AND INDEMNIFICATION AGREEMENT**

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

Name of Parent/Legal Guardian: \_\_\_\_\_

I represent that I am the custodial or legal guardian of the above child, who is participating in the Piedmont College Boys' Basketball Team Camp. In order that the child may participate in the camp, I as the custodial parent/legal guardian of the child, freely and voluntarily sign the Indemnification Agreement.

I understand that there is an inherent danger in participating in any athletic activity. I understand that by permitting my child to participate in the camp, he may sustain a serious injury or may cause other serious physical injury or may suffer or cause damage to or destruction of their property or the property of others. I understand that physical injury may include permanent disability, paralysis, disfiguration or even death. I waive, release, and forever discharge any and all claims for any personal injury (including death), property damage, or other loss, which I may have against Piedmont College, its directors, employees, agents, or any other persons, corporations, or entities connected with or participating in the camp provided by Piedmont College. Further, I agree to indemnify and hold harmless Piedmont College, its directors, employees, agents, or any other persons, corporations, or entities connected with or participating in the camp provided by Piedmont College from and against all claims, lawsuits, liabilities, losses, damages and expenses of every kind whatsoever resulting from any negligence, fault, or lack of due care, or from any cause whatsoever, which are related in any way to the child's participation in the camp provided Piedmont College. This Release of Liability and Indemnification Agreement shall be binding personally and upon the estates of the undersigned.

In the event of illness or injury of my child and reasonable attempts to contact me at my telephone:

Home Phone: \_\_\_\_\_ Business/Emergency: \_\_\_\_\_

have been unsuccessful, I hereby give my consent to have any treatment deemed necessary by a local physician or dentist and the transfer of the child to a hospital, if necessary.

Facts concerning the child's medical history, including allergies, medications being taken, and physical impairments to which a physician should be alerted:

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

Address: \_\_\_\_\_

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

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