University of Kansas
2022 School of Pharmacy Summer Camp Program / Liability Release Form

I/We understand that the University of Kansas, the University of Kansas School of Pharmacy, the University of Kansas School of Pharmacy Summer Camp Program, the Kansas Board of Regents, the State of Kansas and their agents, officers and employees are not responsible for any injuries or illnesses of my (our) child (insert name)__________________________ existing prior to or occurring during participation in the 2021 University of Kansas School of Pharmacy Summer Camp Program.

I/We authorize the employees and/or agents of the University of Kansas School of Pharmacy Summer Camp Program to act in accordance with their best judgment in any situation requiring medical attention, whether an emergency or not until such time as I (we) am (are) contacted to make decisions concerning treatment. I understand that no prescription medication, other than legally prescribed prescription medication brought to camp for conditions currently under treatment, will be administered to my (our) child unless emergency conditions require otherwise.

I (We), on behalf of myself (ourselves) and my (our) child, in consideration of the opportunity for my (our) child to participate in the program, hereby, waive, release, discharge the University of Kansas, the University of Kansas School of Pharmacy, the University of Kansas School of Pharmacy Summer Camp Program, the Kansas Board of Regents, and the State of Kansas and their agents, officers and employees from any claim of injuries or property damage which may be sustained by my (our) child during attendance at and participation in the University of Kansas School of Pharmacy Summer Camp Program. I (We) further agree to indemnify the University of Kansas, the University of Kansas School of Pharmacy, the University of Kansas School of Pharmacy Summer Camp Program, the Kansas Board of Regents, and the State of Kansas and their agents, officers and employees, and to hold the foregoing harmless from any and all claims of injury or property damage which are caused by or are the result of actions or omissions of my (our) child.

x ____________________________ x ____________________________
Signature of Parent or Guardian Date

Health Insurance Information for the Pharmacy Student Camp Participant
Name of child covered: ____________________________
Health Insurance Program/Company: ____________________________
Policy No. or Plan Designation: ____________________________
Name of Primary Individual on the Health Insurance Identification Card: ____________________________
Please attach a copy of the Health Insurance Identification Card.

Return this form with evidence of insurance coverage for the camp participant no later than Monday, June 6, 2022. Documentation may be a copy of an insurance identification/benefits card that reflects health insurance coverage for the camp participant.

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