

## <u>University of Kansas</u> 2022 School of Pharmacy Summer Camp Program / Liability Release Form

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 existing prior to or occurring during participation in the 2021 University of Kansas School of Pharmacy Summer Camp Program.
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.
(We), on behalf of myself (ourselves) and my (our) child, in consideration of the opportunity for my (our) child o 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 Summer Camp Program, the Kansas Board of Regents, and the State of Kansas and their agents, officers and employees, and to nold 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,

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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