Space Coast Surf Camp

Name:_____ Age:_____ D.O.B. _____

Address:_____
Street City Zip code

Mother:_____ Work Phone:_____

Father: _____ Work Phone: _____

Home Phone:_____

Or Legal Guardian:_____ Phone:_____

Adult T-Shirt Size:_____ or Child's Large_____

Please provide relevant medical information:_____

_____

RELEASE FROM LIABILITY AND AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

In consideration to the acceptance of the application of _____ for participation in the Space Coast Surf Camp Program, and with complete understanding that he/she shall take a physical test of swimming skills and also will engage in various physical activities on the beaches and waters of the Atlantic Ocean at a designated time and place, I/we, the undersigned, intending to be legally bound, do hereby, for myself, my heirs executors, and administrators, give my/our approval in his/her participation in any and all of the activities; assume all risks and from the activities; and waive, release, absolve, indemnify, hold death, or damages which may hereafter accrue to me against Space Coast Surf Camp and/or its agents and employees, the organizers and the sponsors, or any of their supervisors appointed by them, any and all of them. I understand that by participation in the Space Coast Surf Camp will engage in various swimming, wading surfing, activities and hazards consequent to them. I/we, the undersigned, hereby certify that no physician, surgeon, or their licensed health care practitioner has advised me, after due inquiry that _____should not participate in any Space Coast Surf Camp activity.

I/we, the undersigned, parent(s) of, a minor, do hereby authorize all representatives of the Space Coast Surf Camp Program, its agents and employees, the organizers and the sponsors, any and all of them, as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the provision of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the afore mentioned physician in the exercise of his judgment may deem advisable.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that none of the above treatment will be withheld if the undersigned cannot be reached.

This authorization shall remain effective until _____ , unless sooner revoked in writing delivered to said agent(s).

Signature of Applicant (minor) _____ Date:_____

Signature of Parent/Legal Guardian_____ Date:_____