SOUND LACROSSE CAMPS LLC

PARTICIPANT WAIVER & RELEASE

Signature is required to participate

In consideration of my participation in SOUND LACROSSE CAMPS LLC sponsored events and activities, I agree to the following:

1. Waiver and Release: I am fully aware of and appreciate the risks, including the risk of catastrophic injury, paralysis and even death, as well as other damages and losses, associated with participation in a lacrosse event and related sports conditioning activities. I further agree on behalf of myself, my heirs and personal representatives, that SOUND LACROSSE CAMPS LLC, along with the coaches, shall not be liable for any injury, loss of life or other loss of damage occurring as a result of my participation in the event.
2. Medical Attention: I hereby give my consent to SOUND LACROSSE CAMPS LLC to provide, through a medical staff of its choice, customary medical / athletic training attention, transportation and emergency medical services as warranted in the course of my participation in SOUND LACROSSE CAMPS LLC sponsored or sanctioned events.
3. Readiness to Compete: I will only participate in those competitions or activities in which I believe I am physically and psychologically prepared to participate.
4. Code of Conduct: I have read and agree to all parts of the Code of Conduct.

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Signature of Participant | Date

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Participant Last Name, First Name (please print) | Team Name

FOR ANY PARTICIPANT WHO IS NOT YET 18 YEARS OLD

As legal guardian of this participant, I hereby verify by my signature below that I have read and fully understand each of the conditions under of the Participant Waiver & Release section for permitting my child to participate in any SOUND LACROSSE CAMPS LLC sponsored events and activities, and I accept each of the conditions, especially the waiver and release set forth in paragraph one.

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Signature of Parent / Guardian | Date

INSURANCE INFORMATION

All participants are required to be covered with insurance for accidental injury. In most instances, family health insurance is adequate. Please indicate your family health insurance plan below.

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Health Insurance Company

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Policy Authorization Number(s)

MEDICAL TREATMENT AUTHORIZATION

I/We being the legal guardians of the applicant, authorize the SOUND LACROSSE CAMPS LLC and its agent's permission to request medical treatment as necessary to ensure the well being of our dependent.

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Signature of Parent / Guardian | Date

FAIRFIELD UNIVERSITY IS NOT RESPONSIBLE OF LIABLE FOR ANY OF THE ACTIVITIES IN RESPECT TO THE CAMP; THE CAMP DIRECTOR IS AN INDEPENDENT CONTRACTOR.