

# 2011 Cal Rugby Summer Camp

Must submit a separate application, waiver and treat & transport form for each participant. **PLEASE PRINT CLEARLY** - Incomplete or illegible forms will not be processed. Please submit this form by Mail, payment must be submitted at time of enrollment.

**ENROLL ONLINE NOW!** at [www.CalBears.com/camps](http://www.CalBears.com/camps)

## Participant Contact Information

Participants Name \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Last First M.I.

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
First Last

School \_\_\_\_\_ Grade in Sept. 2011 \_\_\_\_\_ HS Grad Year \_\_\_\_\_

How did you hear about these camps? \_\_\_\_\_

Parent/Contact E-Mail (**REQUIRED**) \_\_\_\_\_  
(Enrollment confirmation will be sent to this e-mail address)

## Emergency/Medical Information (REQUIRED)

Alternate Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
(Must be different from Parent/Contact Name) Last First

Doctor Information \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Name

Medical Insurance \_\_\_\_\_  
Company Policy # Exp. Date Policy Holder's Name

Medical, Physical or Emotional Conditions (including allergies and disabilities)?  Yes  No

If Yes, please provide information to assist us: \_\_\_\_\_

Medications:  Yes  No List Medications (including inhalers): \_\_\_\_\_

Is your child up-to-date on all state-required Immunizations?  Yes  No

If No, please explain: \_\_\_\_\_

Please list any other health information relevant to camp participation \_\_\_\_\_

## Camp Selection

Rugby Summer Camp (Ages 15-18) July 24 - 27  
 Overnight Camp \$510  Day Camp \$365

Extra Night (Early Arrival) \$75

Height \_\_\_\_\_ Weight \_\_\_\_\_ Yrs. Exp. \_\_\_\_\_

Team/Club \_\_\_\_\_

T-Shirt Size  S  M  L  XL  XXL

Position (Select One):

N/A  Prop  Hooker  Lock  
 Flanker  Backrow  Scrumhalf  Flyhalf  Center  
 Wing  Fullback

Roommate Request \_\_\_\_\_

(Please list only one roommate request, we cannot accommodate several requests)

**NCAA RESTRICTION** - Due to NCAA restrictions, institutional staff members or representatives of its athletics interests shall not employ or give free or reduced admission privileges to a high school, preparatory school or two-year college athletics award winner.

**NONDISCRIMINATION STATEMENT** - In accordance with applicable Federal laws and University policy, the University of California does not discriminate in any of its policies, procedures, or practices on the basis of race, color, national origin, sex, sexual orientation, age or handicap.

**REFUND POLICY** - All requests for refunds, cancellations, or transfers that cannot utilize the manually-issued process must be submitted in writing, via e-mail ([calcamps@berkeley.edu](mailto:calcamps@berkeley.edu)) or fax at (510) 280-1650. We do not take requests for refunds, cancellations, or transfers over the phone. Camps are not prorated and participant substitutions are not allowed. NO refunds are given to campers dismissed from camp for inappropriate behavior. All requests made within 60 days of an original credit card purchase will receive a credit refund. The refund will be credited back to the original credit card within 3-5 business days of your receipt of an e-mail confirmation of the request. All orders paid via cash or check OR if the refund request is made after 60 days of the original purchase will receive a check refund. A check refund will be received within 2-3 weeks of your receipt of an e-mail confirmation of the request. **For Summer Camps ONLY: Refund/Cancellation Fees:** All refund requests received 30 days or less before the start of camp will be reviewed on a case-by-case basis by the Camp Director. All refund requests received 30 days or less before the start of camp will be assessed a \$50 administrative/cancellation fee AND may incur additional costs due to the timing of the request or non-refundable costs which the camp has incurred, such as dorm/meal reservation costs.

## Payment:

CHECK (Payable to "UC Regents")  CASH  OTHER Amount: \_\_\_\_\_ Check #: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Amount Received: \_\_\_\_\_ Order #: \_\_\_\_\_ Date Processed: \_\_\_\_\_ Office Initials: \_\_\_\_\_

**Mail completed enrollment form, waivers and payment to:**

Cal Athletic Camps

Phone: (510) 642-3277

Attn: Rugby Camp

Fax: (510) 280-1650

115 Haas Pavilion

E-Mail: [calcamps@berkeley.edu](mailto:calcamps@berkeley.edu)

Berkeley, CA 94720-4422

Participant's Name: \_\_\_\_\_  
(Last) (First)

Order Number (For Office Use ONLY): \_\_\_\_\_

# ***2011 Cal Athletic Camps Physician Form***

**Please Indicate Camp(s) that this form is for: (If the camp you are attending does not appear below, you do not need to complete this form.)**

## **Football**

- Kicking Camp (June 11-12)
- Full Contact Camp (June 17-19)

## **Girl's Soccer Residential/Academy Camps**

- Junior ID Academy (July 10-14)
- College ID Academy (July 10-14)

## **Rugby**

- Rugby Summer Camp (July 24-27)

## **Boy's Soccer Residential/Academy Camps**

- Junior ID Academy: Session I (June 20-23)
- Junior ID Academy: Session II (July 18-21)
- Premier ID Academy: Session I (June 20-23)
- Premier ID Academy: Session II (July 18-21)

## **Strength & Conditioning**

- Session Dates: \_\_\_\_\_

***This Physician Statement MUST be signed by a Physician prior to submitting it to the University of California. In lieu of this statement, we will accept an official record of any physical performed within the last year, as long as it is signed by a Physician and does not indicate any restrictions, such as indicating that the Physician is only certifying participation in a non-contact sport. Participants will not be allowed to participate unless the Physician Statement is complete or the alternate record of the physical is acceptable.***

I certify that \_\_\_\_\_ is in good health and physically able  
(Participants Name)  
to take part in the camp(s) indicated above.

***PLEASE PRINT LEGIBLY***

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please indicate any health conditions that the patient has that we should know about concerning their participation in this camp (Please use additional forms if necessary).

**Return By Mail, Fax or Delivery To:**

Cal Athletic Camps  
Attn: Athletic Camp Coordinator  
115 Haas Pavilion  
Berkeley, CA 94720-4422

**FAX TO: (510) 280-1650**

If you have any questions, please  
e-mail the camp office at:  
**calcamps@berkeley.edu**

Participant's Name (Last, First): \_\_\_\_\_ Camp: \_\_\_\_\_

*\*A separate waiver is needed for each participant per camp.*

UNIVERSITY OF CALIFORNIA, BERKELEY

CAL Athletic Camps

**Waiver of Liability, Assumption of Risk, and Indemnity Agreement**

**Waiver:** In consideration of being permitted to participate in any way in the Cal Athletic Youth Programs that I have enrolled my child in, as listed on the Registration Form; hereinafter called "The Activity", I, for myself, my heirs, personal representatives or assigns, **do hereby release, waive, discharge, and covenant not to sue** The Regents of the University of California, its officers, employees, and agents from liability **from any and all claims including the negligence of The Regents of the University of California, its officers, employees and agents**, resulting in personal injury, accidents or illnesses (including death), and property loss arising from, but not limited to, participation in The Activity.

\_\_\_\_\_  
Signature of Parent/Guardian of Minor      Date

\_\_\_\_\_  
Signature of Participant      Date

**Assumption of Risks:** Participation in The Activity carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The specific risks vary from one activity to another, but the risks range from 1) minor injuries such as scratches, bruises, and sprains 2) major injuries such as eye injury or loss of sight, joint or back injuries, heart attacks, and concussions to 3) catastrophic injuries including paralysis and death.

**I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent in The Activity. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.**

**Indemnification and Hold Harmless:** I also agree to INDEMNIFY AND HOLD The Regents of the University of California HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of my involvement in The Activity and to reimburse them for any such expenses incurred.

**Severability:** The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

**Acknowledgment of Understanding:** I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, and **understand that I am giving up substantial rights, including my right to sue.** I acknowledge that I am signing the agreement freely and voluntarily, and **intend by my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

\_\_\_\_\_  
Signature of Parent/Guardian of Minor      Date

\_\_\_\_\_  
Signature of Participant      Date

Participant's Age (if minor) \_\_\_\_\_

Participant's Name (Last, First): \_\_\_\_\_ Camp: \_\_\_\_\_

**AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR**

(I) (We), the undersigned parent(s)/guardian(s) of \_\_\_\_\_, a minor, do hereby authorize University of California, Berkeley Health Services or attending medical personnel as agent(s) for the undersigned to consent to any X-ray examinations, anesthetic, medical or surgical diagnosis or treatment, or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code §2000 et. seq.; or any X-ray examination, anesthetic, dental or surgical diagnosis or treatment, or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code §1600 et. seq.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care 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 aforementioned physician or dentist, in the exercise of his/her best judgment, may deem advisable. This authorization is given pursuant to the provisions of California Family Code §6910.

(I) (We) hereby authorize any hospital, which has provided treatment to the above-named minor pursuant to the provisions of California Family Code §6910, to surrender physical custody of such minor to (my) (our) above named agent(s) upon the completion of treatment. This authorization is given pursuant to California Health and Safety Code §1283

These authorizations shall remain effective until **December 31, 2011**, unless sooner revoked in writing delivered to said agent(s).

\_\_\_\_\_  
Signature of Parent/Guardian of Minor Date

**CAL ATHLETIC YOUTH PROGRAM PARTICIPANT AGREEMENT**

- This health history is correct so far as I know, and my son/daughter has permission to engage in all prescribed camp activities, except as noted by me. My son/daughter is in good health.
- I understand that I am required to have accidental medical coverage for the child listed on this application, and I verify that the information provided on this form is accurate and true. I understand and agree that if I do not have accidental medical coverage for the child listed on this application, I will be financially responsible for all charges and fees incurred in the rendering of said treatment
- I understand that at the discretion of camp/program supervisor and/or staff my child may be dismissed from the camp/program, without refund, for inappropriate behavior.
- I understand that at the conclusion of the scheduled camp/program time, Cal Athletic Youth Programs are no longer responsible for my child.
- I give permission to use, reprint, and produce any photographs or videos taken of me or my child and written materials supplied by me or my child in the form of evaluations during the Cal Athletic Youth Programs. I understand that such material will be used for university marketing purposes only.

\_\_\_\_\_  
Signature of Parent/Guardian of Minor Date Signature of Participant (18 years of older) Date

# Cal Coaches Camp Medication Form

Return completed form to your camp Health Care Coordinator

Name of Camper \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(last) (first)

Camp \_\_\_\_\_

**FORM MUST BE COMPLETED BEFORE ANY MEDICATION IS BROUGHT TO CAMP**  
**This form must be completed for prescribed and non-prescribed medications by the parent/guardian the physician (for prescription medication) and contain proper signatures before any medication can be administered at camp. All medications, whether prescribed or non-prescribed, are kept in the camp office. If your physician would like your child to carry either an asthma inhaler or emergency medication (i.e. EpiPen or Inhaler), PART 3 must be completed by the doctor, parent, and child.**

**PART 1: PARENT/GUARDIAN:** Both prescribed and non-prescribed medications will be administered by authorized camp personnel in the manner and dosage given. By signing below I hereby request that authorized personnel assist this camper in taking the medication in the manner and dosage given. *I understand all medications must be in their original container.*

\_\_\_\_\_  
Parent/Guardian Signature Printed Name/Relationship Date

(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Main contact phone Alternate contact phone

**PART 2: PHYSICIAN (Signature not needed if non-prescription medication) IF REQUIRED by Camp**

Name of Medication \_\_\_\_\_ Form \_\_\_\_\_ Dose \_\_\_\_\_  
(liquid, tabs, inhaler, etc.)

Schedule of Doses \_\_\_\_\_ Date to Stop Medication \_\_\_\_\_

Restrictions, Cautions, Side Effects \_\_\_\_\_

\_\_\_\_\_  
Physician Signature Printed Name Date

Physician Phone # (\_\_\_\_\_) \_\_\_\_\_ Address \_\_\_\_\_

**PART 3: PERMISSION TO CARRY ASTHMA INHALERS/EPIPENS (Part I & II Must be completed)**  
TO BE COMPLETED BY THE PHYSICIAN: The above-named camper has been instructed in the proper use of their asthma inhaler/emergency medication. The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the asthma inhaler/emergency medication at camp. He/she understands the purpose, appropriate method, and frequency of use of asthma inhaler/emergency medication.

\_\_\_\_\_  
Physician Signature Printed Name Date

TO BE COMPLETED BY THE PARENT/GUARDIAN: I permit my child to carry the above-listed asthma inhaler/emergency medication as ordered by his/her physician.

\_\_\_\_\_  
Parent/Guardian Signature Printed Name Date

TO BE COMPLETED BY THE CAMPER: I have been instructed in the proper use of my medication and will take it as prescribed to me by my physician.

\_\_\_\_\_  
Camper Signature Printed Name Date

**PART 4: CAMP DIRECTOR (to be completed by Health Care Coordinator/designated camp staff)**

Person(s) designated by camp Health Care Coordinator to assist camper in taking medication above

\_\_\_\_\_  
Signature of Camp Health Care Coordinator or designated camp staff Date

*This information to be used by Camp Director and authorized personnel only.*