

Southern Miss Baseball "Fall Showcase Camp"

November 22, 2014

(Online Registration ends Nov. 20)
(Walk-up Registration is allowed)

The "Fall Showcase Camp" designed to allow current High School Freshman through Junior College Sophomore (JUCO FRESHMAN must be an Academic Qualifier) baseball players the chance to showcase their abilities and receive instruction from current USM coaches, various Junior College coaches, and other 4-year Institutions. The Camp is set to take place at Pete Taylor Park, with Registration beginning at 11:00AM. The Camp will begin at 12:00 PM and will end when all camp participants have completed the workout. The price per camper is \$155.

This cost includes instruction, insurance, and a USM Camp T-shirt. The itinerary will include instruction specific to each participant's defensive position, improving 60 times, and hitting at Pete Taylor Park. Any pitcher will be allowed to participate at both positions.

What to Bring: Cleats, Tennis Shoes/Turfs, Bat, Batting Gloves, Helmet, Catcher's equipment, Baseball Pants, Hat, Any other equipment one would use.

**Ages: 9-Junior College Sophomores
(Junior College Freshman must
have been an Academic Qualifier
out of High School)**

Dates: November 22, 2014

Location: Pete Taylor Park

Time: 11:00 AM Registration

12:00 Camp begins

Costs: \$155 (Includes USM Camp T-shirt & Insurance)

Limited to First 100 Registered

*Credit Card Users should
register:*

www.southernmissbaseballcamps.com. (Fall Showcase Camp tab)

Cash/Check:

All Checks Payable to:

USM BASEBALL

*Where to send mail-in Registration and
Waiver:*

**USM BASEBALL ATTN:
COACH CLINT BROWN/ (Fall
Showcase Camp)
118 COLLEGE DRIVE #5017
HATTIESBURG, MS 39406**

*All Southern Miss Baseball camps and clinics are open
to any and all entrants, limited only by number, age,
grade level and/or gender*

Name: _____

DOB: _____ AGE: _____

Graduation Year _____

Address: _____

Apt.: _____ City _____

State _____ Zip _____

Player's Cell Phone: _____

E-Mail: _____

Alt E-Mail: _____

Alternate Phone: _____

T-Shirt Size: _____

Name of High School: _____

Height _____ Weight _____

Bat (circle) R L Throw (circle) R L

Primary Position _____

Secondary Position _____

USM USE: Date Rec'd _____

Amt. Paid _____

Check # _____

Waiver Signed _____

WAIVER OF LIABILITY AND INDEMNIFICATION AGREEMENT
CONSENT TO MEDICAL TREATMENT

EACH PARTICIPANT MUST PROVIDE THIS COMPLETED FORM PRIOR TO PARTICIPATION IN ANY CAMP ACTIVITY. PHOTOCOPIES ARE ACCEPTABLE

In consideration of my child being allowed to participate in this clinic, **I hereby RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE** The University of Southern Mississippi or the State College Board of the State of Mississippi, and their officers, servants, agents, or employees (hereinafter referred to as RELEASEE) from any and all liability, claims, demands, or course of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me/my child, or to any property belonging to my child, **WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEE**, or otherwise while participating in this clinic or while in, on, or upon the premises where the clinic is being conducted.

To the best of my knowledge, my child is in good physical condition, and I am not aware of any physical infirmity, which would place my child at risk to participate in any way with the clinic's activities. I am fully aware of the risks and hazards associated with this clinic. **I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISK OF LOSS, PROPERTY DAMAGE, OR PERSONAL INJURY, INCLUDING DEATH**, that may be sustained by my child, or any loss or damage to property owned by me/my child, as a result of being engaged in the clinic's activities, **WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEE** or otherwise. I further hereby **AGREE TO INDEMNIFY AND HOLD HARMLESS THE RELEASEE** from any loss, liability, damage, or cost, including court costs and attorney's fees, that may accrue related to my child's participation in this clinic, **WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEE** or otherwise.

During the period of the clinic, I hereby give permission for the staff of The University of Southern Mississippi Department of Intercollegiate Athletics, or the staff of the clinic to administer appropriate medical attention to my child in the event of an accident, illness, or injury. I will be responsible for any and all costs of medical coverage and treatment provided not covered by insurance.

It is my express intent that this Waiver of Liability and Hold Harmless Agreement/Consent to Medical Treatment shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a **RELEASE, WAIVER, DISCHARGE, AND COVENANT NOT TO SUE** the above-named **RELEASEE**. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement/Consent to Medical Treatment shall be construed in accordance with the laws of the State of Mississippi. In signing this release, I acknowledge and represent that I have read and understand it and sign in voluntarily; I am at least eighteen (18) years of age and fully competent; and I execute this release for full, adequate, and complete consideration fully intending to be bound by the same.

I HAVE READ THIS WAIVER OF LIABILITY AND FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Parent/Guardian Printed Name Signature Date Emergency #

INSURANCE: This clinic carries an excess medical insurance policy to cover medical expenses for injuries/accidents that occur in the course of the clinic's activities. Medical expenses that are declined for payment through the participant's personal insurance and/or through the excess policy become the responsibility of the participant's parent/guardian.

INSURANCE INFORMATION:

Company Name Policy Number Policy Holder Group Number Phone Number

AMERICANS WITH DISABILITIES ACT: For individuals with disabilities requiring special accommodations, please contact the clinic director within a minimum of seven days of the first day of the clinic so the proper consideration may be given to the request.

PHYSICIAN'S STATEMENT: I hereby certify that _____ has no restrictions that would prevent him/her from active and full participation in any and all activities related to the clinic.

Physician's Signature Date

****Copy of recent (within 90 days) school physical is acceptable in lieu of physician signature****

Known Allergies: _____ Tetanus Booster Date: _____

Medications camper will bring to camp: _____