



2 I.U. Willets Road – Roslyn, New York 11576
(Phone) 516-365-7760 – (Fax) 516-869-0964 – www.buckleycamp.com

2019 Under 18 Emergency Release Form

The undersigned being the parent/guardian of the staff member listed below on this form, releases and discharges Buckley Day Camp (BDC), including but not limited to, its staff, counselors, directors, and employees, as well as, the Buckley Country Day School, including but not limited to its staff, employees, and related entities from any claim which the said staff member or undersigned may have, individually and/or as parent/guardian of our child(ren), as well as any action that our child(ren) may have against the aforesaid parties, except for negligence resulting from any act or action, damage and/or injury that may befall our child(ren) as a result of his/her being a staff member at BDC and engaging in any type of activity resulting in the injury or damage to our child(ren).

The undersigned consents that his/her child(ren) may participate in all camp activities on or off the premises, and the undersigned releases the aforesaid parties from any and all claims that may arise as a result thereof.

The undersigned understands that certain risks and dangers may be involved in the conduct of activities at the BDC and holds harmless the aforesaid parties from any claims.

The undersigned, who is one of the parents having legal custody, or the legal guardian of the staff member named below, a minor, hereby authorizes the adult chaperone or other personnel of the BDC into whose care said minor has been entrusted, to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis of treatment and hospital care to be rendered to said minor under the general or special supervision and on the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act, or to consent to an x-ray, examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care to be rendered to said minor by a dentist licensed under the provisions of the Dental Practice Act.

In the event that I cannot be reached at the numbers listed below, I hereby give my permission to BDC to hospitalize, secure proper treatment for, to order injection, anesthesia, or surgery for my child(ren) named below.

Please Check:

I fully agree with the above statement.

I refuse to give my consent to emergency medical treatment recommended by a physician for my child(ren) during participation in the program. Furthermore, I refuse to give my permission for BDC staff to authorize appropriate emergency medical treatment.

Staff Members Name: _____

Parent/Guardian's Signature: _____ Date: _____

Print Name of Parent/Guardian: _____

Home Telephone #: _____ Cell or Work Telephone #: _____