



TROJAN DIVE CAMP 2017 TRAVEL and HOUSING PLANS



TRAVEL PLANS:

Name: _____ Age: _____ M _____ F _____

Date/Time/City Arrival: _____ Airline: _____

Date/Time/City Departure: _____ Airline: _____

Arrangement for Ground Transportation From Airport to USC: YES _____ NO _____

NOTE: \$50 round trip ground transportation to and from the airport will apply.

HOUSING PLANS:

Please Check or Circle the Following Preference:

Day Camper: _____

Resident Camper: _____ Roommate Preference: _____

All information and the camp fees must be returned by **Monday, May 29th, 2017.**

PAYMENT OPTIONS:

Make Checks Payable to: Trojan Dive Club

Send to: Hongping Li
USC
Uytensu Center, 1026 W. 34th St
Los Angeles, CA 90089-2511

PapPal: <http://www.trojandivecamp.com>

Note: A handling fee of 5% will accompany this form of payment



TROJAN DIVE CAMP RULES and REGULATIONS



1. Each camper must be aware of, and abide by, all federal, state and local laws, ordinances and university regulations.
2. Behavior considered to be harmful to the honor and reputation of USC, the Trojan Dive Club or the campers is prohibited.
3. Consumption of alcohol or smoking is strictly prohibited.
4. Drugs may not be used at any time except as approved by the medical authorities.
5. Divers are expected, in both attitude and behavior, to make a positive contribution to their sport.
6. Respect yourself, your campers, and the camp staff.
7. Respect USC property and facilities including dorms, cafeteria, and diving equipment.
8. Individual activities without permission and an adult supervision are not permitted.

I have read, understand and agree to follow these rules and regulations.

Diver Name: (Print) _____

Signature: _____ Date: _____

Parent or Guardian: (Print) _____

Signature: _____ Date: _____



TROJAN DIVE CAMP PARTICIPANT WAIVER



The Trojan Dive Camp offers programs on a limited basis. There are certain risks inherent in the use of equipment and/or participation in certain programs which you should consider before you begin such activities. As a participant in this program, the undersigned, on behalf of us and our minor dependents (collectively, "our"), understand that participation can involve physical activity, which could result in injury. The undersigned also understand that use of the facilities is exclusively limited to the area(s) in which the program is being conducted and that use will be strictly under staff supervision. For, and in consideration of the Trojan Dive Camp sponsoring program, and the University of Southern California allowing use of its facilities for this program, and with the understanding of the risks involved in our participation, the undersigned on behalf of ourselves, our dependents and heirs agree to release and forever discharge the Trojan Dive Camp and the University of Southern California, their officers, directors, employees, contractors and agents from any and all liabilities, demands or claims for loss or damage resulting from an injury or damage which may be sustained on account of participation in these classes or programs, or use of facilities.

Diver's Name: _____ Birthdate: _____
Email: _____ Cell Phone: _____
Street Address: _____ City: _____ Zip: _____

Print Name: _____ Relationship: _____
Signature: _____ Date: _____

Parent or Guardian if participant is a minor

EMERGENCY MEDICAL FORM

I the undersigned/or parent, or legal guardian of _____ ("Participant"), do hereby authorize and consent to Trojan Dive Camp ("Authorized Party"), obtaining for the Participant any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital or emergency room care facility ("Medical Facility") care to be rendered to the participant under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or Medical Facility care being required and, except as expressly limited below, is given to provide authority and power to render care which a Physician and Surgeon or Dentist in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned by telephone at the numbers listed below prior to rendering treatment to the participant, but that any of the above treatment will not be withheld if the undersigned cannot be reached. If the Authorized Party is a corporation this authorization shall include any officer, director or employee of said corporation or its affiliates. It is further understood that I (we) the undersigned are responsible for all charges for the above-mentioned diagnosis, treatment or hospital care.

This authorization is given pursuant to Section 25.8 of the Civil Code of California.

Limitations: (if any) _____ Signature: _____ Date: _____

THIS CONSENT SHALL REMAIN EFFECTIVE UNTIL _____

MEDICAL INFORMATION:

Birthdate: _____ Last Tetanus Booster _____

Print Father's Name _____

Employer & Address: _____

Print Mother's Name _____

Employer & Address: _____

Physician OR Christian Practitioner: _____

Known allergies to drugs or foods:

Insurance Co: _____ Policy Number _____

EMERGENCY CONTACT

PHONE #: _____

Cell Phone: _____

Phone: _____

Cell Phone: _____

Phone: _____

Phone: _____