CONSENT FORM – ATHLETES IN TRAINING: FOCUS ON INJURY PREVENTION

NAME: ________________________________

DATE: ________________________________

ATHLETE INFORMATION: ☐Male ☐Female Date of Birth: _______________ Shirt Size: ________

SCHOOL:_________________________ **GRADE IN UPCOMING SCHOOL YEAR:**_______________

SPORTS PLAYING IN THE UPCOMING YEAR: ____________________________________

ADDRESS: ____

PHONE: _________________________________ **EMAIL:** _______________________________

EMERGENCY CONTACT: ______________________ **PHONE NUMBER:** _______________________

PRIMARY CARE PHYSICIAN/PEDIATRICIAN: ____

HOW DID YOU HEAR ABOUT THE INJURY PREVENTION PROGRAM?_________________________________

SELECT A PROGRAM: ☐**Personal Training** ☐**June Focus Group** ☐**July Focus Group**

MEDICAL HISTORY: As a matter of policy, we must have all participants fill out a health risk questionnaire.

YES NO 1. Do you have a bone, muscle, ligament or joint injury that currently bothers you?
If yes, Explain: ____

YES NO 2. Do you have a history of bone/muscle/ligament injury and/or been injured recently (within last 6 months)?
If yes, Explain: ____

YES NO 3. Are you being treated/or have been treated by a doctor for any illness that may be affected by an exercise program? (ie, diabetes, asthma, seizure disorder, heart condition)
If yes, Explain: ____

YES NO 4. Are you currently in physical therapy for any condition?
If yes, Explain: ____

YES NO 5. Are you currently seeing a chiropractor or massage therapist for neck/back pain?
If yes, Explain: ____

YES NO 6. Have you ever limited/been told to limit physical activity due to pain?
If yes, Explain: ____

YES NO 7. Are you pregnant?

I hereby certify that the above information is true and correct to the best of my knowledge.

If you have answered YES to any question above, participation in the program is determined at the discretion of the CRMC Certified Athletic Trainer. The Certified Athletic Trainer has the right to request physician clearance if he/she feels it is necessary.

I have read the above statement and waive the right to obtain physician clearance. I hereby, assume all risks associated with my participation in the Injury Prevention Program at the Sam B. Cook Healthplex. ____. (Athlete/parent/legal guardian must initial)

<u>CONSENT TO PARTICIPATE:</u> must be signed before engaging in exercise at the Sam 8. Cook Healthplex

I voluntarily consent to participate in the injury prevention program. I understand and am aware that the strength, flexibility and aerobic exercises, including the use of equipment, is a potentially hazardous activity. I understand that the activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment, knowing the danger involved. I hereby release Capital Region Medical Center (CRMC) from all claims or liabilities for personal injury or property damage I may sustain on account of **my** participation in the program. Further, I consent to treatment in the event of a medical emergency and consent that in the event of such a medical emergency, the contents of this questionnaire, including copies thereof, may be provided to ambulance personnel, emergency room personnel, physicians, nurses, and other healthcare providers who may be providing treatment or care to me in such medical emergency.

I hereby consent and agree that moving or still pictures may be taken of me by CRMC staff (and whomever they may designate) to be used and displayed at their discretion.__________________(your initials}

My signature below indicates that I have read and understand the foregoing and that I do hereby adopt it in its entirety.

Signature______________________________________**Print Name**______________________________________

If the athlete is a minor, the parent/legal guardian's signature is required.

X **Date:**

(Signature of athlete or parent/legal guardian)