

ST. VINCENT SPORTS PERFORMANCE AND SPORTS MEDICINE PROGRAM
CONSENT FORM

Name: (full legal name) _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell: _____ Email: _____

Birth Date: _____ Age: _____

If under age 18, please provide legal guardian/parent name(s): _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Cell: _____ Other: _____

Initial

Sports Performance: I voluntarily agree to participate in the St. Vincent Sports Performance Program (hereinafter "Sports Performance"). The Sports Performance program has been fully explained to me and I have been given the opportunity to ask questions. I have been informed that if I have any questions regarding Sports Performance, the expected benefits, the risks or the alternatives to participation in Sports Performance, I may ask those questions before signing this consent form.

I understand that my total fee is due at the time of the first session. I understand my fee to be: _____.

I understand that my attendance is voluntary; however, I am expected to attend each assigned class/training session. My absence for any reason is not cause for a refund. I understand that I will be charged for every training session that I do not cancel at least twenty-four (24) hours prior to the appointed time. Training sessions cancelled within twenty-four (24) hour notice will be rescheduled at a later date (maximum of two (2) make-ups per eight (8) week session).

Initial

Sports Medicine: I voluntarily agree to participate in the St. Vincent Sports Medicine Program (hereinafter "Sports Medicine"). I understand that all Sports Medicine services will be provided by licensed health care professionals in accordance with the policies and procedures at St. Vincent Hospital and Health Care Center, Inc. I further understand that the confidentiality and privacy of such services shall be maintained in accordance with St. Vincent's notice of privacy practices.

I agree to accept full responsibility for participation, my actions, and any injuries that may result from my voluntary participation in the Sports Medicine program. **I am without health issues or have disclosed any health issues which would preclude or increase any risk of injury from my participation in this program.** I accept responsibility to abide by program rules of conduct and respect my assigned and reserved program timeframe. I release St. Vincent Hospital and Health Care Center, Inc., its employees, agents, affiliates, sponsors, and all program instructors from any and all liability in connection with my participation in the program. I acknowledge that no guarantees have been made to me as a result of my participation in the program.

Photograph/Autograph Prohibition: I understand that I am an "At Will" participant and will respect the efforts of other participants. I understand the request for autographs or photographs of other participants is strictly prohibited. I also understand that any attempt to seek autographs or photographs from Sports Performance or Sports Medicine program participants is cause for expulsion from either program without a refund.

I HAVE READ AND UNDERSTAND THE ABOVE-STATED INFORMATION. ANY QUESTIONS WHICH HAVE ARISEN OR OCCURRED TO ME HAVE BEEN ANSWERED TO MY SATISFACTION.

Signature of Participant

Date

Signature of Legal Guardian and/or Parent

Date