



Sports Medicine Center for Young Athletes

CONSENT FOR PARTICIPATION WAIVER AND RELEASE

This Consent for Participation and Waiver and Release (“Agreement”) is legally binding. Do not sign this Agreement until you have read it carefully and understand its contents. This Agreement may affect, reduce or eliminate you/your child’s legal rights in certain circumstances.

I am the parent or legal guardian of the minor child (hereafter the Young Athlete): _____

I hereby consent for this Young Athlete to participate in the following sports training class (the “Class”) sponsored by the Sports Medicine Center for Young Athletes at Children's Hospital & Research Center Oakland (“CHRCO”): _____

As a condition to my Young Athlete’s participation in this Class, I understand, represent, and agree as follows:

1. My Young Athlete has no medical or health condition affecting his/her ability to safely participate fully in, or that will be harmed by, the activities of this Class except as follows: _____

If there is any change in my Young Athlete’s current medical health condition that affects his/her ability to safely participate fully in, or that will be harmed by the activities of this Class, I am solely responsible for restricting my Young Athlete’s participation in the Class to accommodate such change(s).

2. I am responsible for the cost of any medical care provided by CHRCO or any other health care provider to my Young Athlete in the event of emergencies.
3. I hereby waive, release, discharge, and hold harmless CHRCO (including but not limited to its Sports Medicine Center for Young Athletes), its affiliated partners, and their respective staff, officers, trustees, directors, employees, agents, contractors, physicians, and other participants in the Class (hereinafter individually and collectively referred to as “Released Party”) from liability for any act, omission or negligence in connection with or in any way related to my Young Athlete’s participation in the Class, including, without limitation, any inoculations, general medical treatment, or emergency medical treatment, including surgery, rendered to my Young Athlete as a result of injuries incurred in the course or as a result of participating in the Class, unless the same results from any willful misconduct or gross negligence on the part of such Released Party.
4. I agree to defend, indemnify, and hold harmless Released Party from or in connection with any and all liability, loss expense, attorneys’ fees, or claims for injury or damages arising out of my Young Athlete’s participation in the Class unless the same results from any willful misconduct or gross negligence on the part of such Released Party.
5. This Agreement may not be modified orally. This Agreement shall be binding upon the Young Athlete and each person who has signed it and his or her respective heirs and legal representatives.
6. This Agreement will be governed by and construed in accordance with the laws of the State of California, and exclusive venue of any action brought hereunder will lie in Alameda County, California.

Parent/Guardian (print name)

Parent/Guardian Signature

Date



Sports Medicine Program for Young Athletes

Sports Performance and Injury Prevention Program

Registration Form

For questions or registration confirmation, please call the Sports Medicine Center at 510-428-3558, ext. 3.

Date _____ I'm registering for the _____ class.

Patient Information

Child's First Name _____ Last Name _____

Age _____ DOB ____ / ____ / ____ Gender Female Male Grade _____

Sport _____

Parent/Guardian Name _____ Relationship _____

Daytime Phone _____ Alternate Phone _____

Parent/Guardian Name _____ Relationship _____

Daytime Phone _____ Alternate Phone _____

Child's Address _____ City _____ Zip _____

Emergency Phone Number _____ Email _____

Background information

How did you learn about the class? _____

What do you hope to accomplish for your child? _____

Is there anything we need to know in order to better understand your child (e.g. recent injury, sports goal, learning disability)? _____

Is there anything you would especially like for us to include in the class? _____

What other sports training programs has your child tried? _____

Children's Clinical/Health History

Has your child had any of the following?

Please check Yes or No

| | Yes | No |
|--|-----|----|
| Allergies | | |
| Anemia, blood disease, bleeding tendencies | | |
| Nutrition concerns | | |
| Arthritis, rheumatologic disease | | |
| Diabetes | | |
| Epilepsy, seizures, fainting, concussion | | |
| Family history of heart disease before age 50 | | |
| Heart abnormality/arrhythmia | | |
| Hernia | | |
| High blood pressure | | |
| History of fractures | | |
| Neurological disorders | | |
| Physical disability or impairment that needs special attention | | |
| Thyroid problem | | |

Is there any reason your child shouldn't exercise? _____

Are there any other physical or mental problems we should know about? _____

Child's Physician _____

May we contact the physician for pertinent information?

Yes No Phone # _____

Current medications _____

Health insurance _____

Sports Medicine Center's sports performance and injury prevention classes are not a covered service for insurance carriers.

Payment is due at time of registration. Please mail this completed registration form and \$ _____ to Children's Hospital Oakland, Sports Medicine Center, 744 52nd St., Oakland, CA 94609 or fax to 510-597-7045.

Signature of Parent/Guardian or Athlete (if age 17+) _____