EXCEL-R-ATION
PHYSICAL THERAPY AND SPORTS TRAINING

Personal Training Waiver of Liability

(For all purposes in this document Excel-R-ation Physical Therapy is referred to as "Excel-R-ation")

I understand and am aware that the use of the Excel-R-ation facilities and equipment has inherent and unanticipated and unknown risks and dangers that may cause injuries or death. I expressly assume all risk of injury or death that may be sustained during my use of the facilities and equipment, defects in the facilities and equipment, the negligence of others and my own negligence or misuse. I understand that participation should not cause injury to me. However, in the event of injury, initial first aid will be provided. If further medical attention is needed, I must look to my own health insurance policies for medical coverage.

In consideration of being permitted to use the Excel-R-ation training facilities, services and equipment, I hereby release, acquit and discharge Excel-R-ation, its successors and assigns, and its officers, directors, agents and employees of and from all claims and liability of any kind. I agree that I will not sue or commence any action of any kind against Excel-R-ation, its successors and assigns and its officers, directors, agents, or employees.

In consideration of being permitted to use the Excel-R-ation facilities and equipment, I agree to indemnify and hold harmless Excel-R-ation, its successors and assigns, and its officers, directors, agents and employees of and from any claims, demands, liability, or judgments arising out of my use of the Excel-R-ation facilities and equipment.

I understand that the Excel-R-ation staff is relying on all information provided by me regarding my medical history and condition before allowing me to participate in any evaluation or program, and I certify the information to be true and correct.

_____

Athlete Name (Please print)

_____ _____

Signature of Athlete Date Signature of Parent / Guardian if athlete is a minor Date

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Medical History Information

Name _____
Date of birth _____
Sport _____
Home phone # _____
Parent name _____
Parent phone # _____

Date _____
School _____
Year in school _____
Cell # _____
Emergency contact name _____
Emergency contact phone # _____

Do you have problems with:

Headaches – needing treatment	Yes	No
Heart	Yes	No
Breathing, e.g., asthma	Yes	No
Abdominal pain	Yes	No
Dizzy spells / fainting	Yes	No
Black outs	Yes	No
Eyes (except glasses)	Yes	No
Hearing or ears	Yes	No
Arthritis	Yes	No
Joint pain or swelling	Yes	No
Knees – injury, weak, swelling	Yes	No
Spine – back or neck	Yes	No
Broken bones	Yes	No
Kidneys	Yes	No
Bladder	Yes	No
Diabetes	Yes	No
High blood pressure	Yes	No
Cancer	Yes	No
Operations (surgeries)	Yes	No
Varicose veins	Yes	No
Skin disorders	Yes	No
Other major injuries	Yes	No
Drug allergies	Yes	No
Eating disorder	Yes	No
Allergies	Yes	No
Numbness or tingling in arms, hands, legs, or feet	Yes	No
Skin rashes	Yes	No
Have you ever become ill from exercising in the heat?	Yes	No

Have you had any problems with muscles, tendons, bones, or joints? ***If yes, check the following & explain***

Head	Elbow	Hip
Neck	Thigh	Back
Wrist/hand	Knee	Chest
Shin	Calf	Finger
Ankle	Upper Arm	Forearm
Shoulder	Foot	

If Yes above, explain _____
_____

A. What physical activities have you been doing in the last two months?
_____

B. Have you ever been knocked unconscious or had a seizure? Yes / No
Explain: _____

C. Have you ever had a cervical spine injury? Yes / No
Explain: _____

D. Do you have any permanent handicap or disability? Yes / No
Explain: _____

E. Are you currently under a physician's care? Yes / No
Explain: _____

F. Are you currently taking any supplements, medications or drugs? Yes / No
Explain: _____

G. Have you ever had any problems from exercising such as passing out, been dizzy or had chest pains before or after exercise? Yes / No
Explain: _____

H. Are you allergic to any medications? Yes / No
Explain: _____

I. Do you wish to gain or lose weight? Yes / No Gain / Lose

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EXCEL-R-ATION
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Permission to Provide Medical Treatment

I hereby give my permission for myself / my son/daughter_____ to undergo medical treatment for any injury or illness that I / my child may sustain or acquire while engaged in any training at Excel-R-ation Physical Therapy and Sports Training. I understand that the Excel-R-ation staff will perform only those procedures which are within their training, credentialing, and scope of professional practice to prevent, care for, and rehabilitate injuries.

In the event that more serious medical procedures are required, such as surgery or other invasive procedures, I understand that attempts will be made to contact me for consent, if the participant is a minor.

I understand that if I / my child suffer(s) a potentially life threatening injury or illness, and in the event that if the participant is a minor and I am unable to be contacted within a reasonable period of time, that I authorize a duly licensed medical practitioner to perform such procedures as may be medically necessary.

I have been given the opportunity to ask questions regarding this release, and all of my questions have been answered to my satisfaction. Having understood the above agreement, I freely sign this Permission to Provide Medical Treatment.

_____
Athlete Name (Please print)

_____ _____
Signature of Athlete Date Signature of Parent / Guardian if athlete is a minor Date

_____
Phone number of Parent/Guardian

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Authorization for Medical Treatment of Minor in the Absence of Parent

❒ I am the parent
❒ guardian
❒ other person having legal custody _____
(*describe legal relationship*)

of (*name of minor*)_____, a minor.

In the event that the minor referred to above attends a physical therapy session without a parent or guardian, I hereby consent to and authorize Excel-R-ation Physical Therapy to render care as ordered under the referral of Dr _____.

I understand that this authorization may be given in advance of any specific diagnosis or treatment, but is given to provide authority to Excel-R-ation Physical Therapy to give consent to any and all such diagnoses and treatments rendered by the staff member coordinating the case of my child.

I also hereby authorize the treatment and administration of emergency care for my minor child listed above in the event of a medical situation occurring during my absence or if the staff members are unable to contact me.

These authorizations shall remain effective for one year from the date signed, unless sooner revoked in writing by me, and delivered to the Excel-R-ation Physical Therapy.

_____ _____
Parent or legal representative signature Date

Minor's birthdate:_____
Allergies to drugs or food: _____
Conditions for which minor is currently being treated: _____
Current medications: _____
Restrictions on activity: _____

Primary care physician (name and telephone number): _____

Mother's Name: _____
Telephone numbers:
Work _____
Home _____
Other _____

Father's name: _____
Telephone numbers:
Work_____
Home _____
Other _____

_____ _____
By Excel-R-ation Witness Date