

Name: \_\_\_\_\_ Sport: \_\_\_\_\_ Date: \_\_\_\_\_

### ASSUMPTION OF RISK

BY ITS NATURE, PARTICIPATION IN INTERCOLLEGIATE ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG TERM CATASTROPHIC, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN TO DEATH. Although serious injuries are not common in supervised intercollegiate athletic activities, it is possible only to minimize, not eliminate the risk.

Participants can and have the responsibility to help reduce the chance of injury. STUDENT-ATHLETES MUST OBEY ALL SAFETY RULES, REPORT ALL ATHLETIC INJURIES TO THE ATHLETIC TRAINERS, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT ALL EQUIPMENT DAILY.

By signing this form, you acknowledge that you have read and understand this warning. STUDENT-ATHLETES WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PORTION OF THE FORM.

Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICAL CONSENT

I hereby grant permission to Johnson State College team physicians and Athletic Training staff to provide medical care to myself in the event that I become injured while participating in intercollegiate athletics. I understand that any treatment, medical, or surgical care that is provided to me will be done only if it is considered medically necessary for my health and well being.

Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize and request JSC athletic trainers and / or their consulting physician (s) to furnish any and all requested information to their physicians, or athletic trainers, which directly pertains to my participation in athletics at JSC. Said authorization shall include, but is not limited to: information concerning my physical condition, illnesses, injuries, treatment, hospitalizations, examination, X-rays, or other forms of diagnostic testing. I hereby fully discharge all parties to whom this authorization extends from any and all penalties of breach of student-athlete confidentiality.

Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICAL REFERRAL PROCEDURE EXPLANATION

Any appointment made with specialists (orthopedist, podiatrist, etc.) may require a referral form from your primary care physician. It is your responsibility to acquire this referral. JSC is not responsible for any medical expense incurred while participating in intercollegiate athletics. Participation in athletics at JSC is limited to athletes covered by medical insurance. JSC athletics offers no coverage to athletes.

Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Sport: \_\_\_\_\_