

Sisters of Charity Providence Hospitals

CONSENT/ RELEASE AND WAIVER

Participant's Full Name

Date of Birth

Social Security Number

Name of School

Name of Program

As the parent or legal guardian of the above named Participant, I hereby give my consent to Sisters of Charity Providence Hospitals ("Providence") to provide sports health services to the Participant as part of his/her participation in the above-mentioned Program. Providence's services may include, but may not be limited to: screenings, physical exams, and athletic trainer services. I grant permission to Providence's employees or contractors to provide such services to Participant as deemed necessary by Providence or District for any athletic injury prevention or treatment. I further grant permission for Providence employees or contractors to treat Participant for any injury or condition that arises out of Participant's activity in the above named program.

I understand that Providence's or contractors providing services at the above named program are not necessarily physicians, medical doctors, or nurses. I understand that the services provided by Providence relate to athletic training services, and are not intended to be a complete medical examination. I understand that the above named program's activities are, by their nature, capable of causing injury to the Participant.

I hereby fully release Providence, and all of Providence's employees or contractors, from any and all liability associated with the care, treatment, examination, or other health services provided to Participant as part of Participant's participation in the above named program.

Authority or Relationship of Representative
(Unless parent, attach copy of documentation of authority,
e.g., a court order designating guardianship)

Signature of Personal Representative/Guardian

Signature of Student

Date