

Waiver and Release of Liability

2009-2010

DISCLAIMER: TRIAD GYMNASTICS IS NOT RESPONSIBLE FOR ANY INJURY (OR LOSS OF PROPERTY) TO ANY PERSON WHILE PRACTICING, TRAINING, TAKING CLASS, COMPETING, PARTICIPATING IN OPEN GYM, SPECIAL EVENTS, DEMONSTRATIONS, OR SHOWS OR IN ANY OTHER WAY INVOLVED IN GYMNASTICS, CHEERLEADING, PRESCHOOL, OR TEAMS AT TRIAD GYMNASTICS CLUB FOR ANY REASON WHATSOEVER, INCLUDING ORDINARY NEGLIGENCE ON THE PART OF TRIAD GYMNASTICS, ITS OWNERS, OFFICERS, AGENTS, OR EMPLOYEES.

In consideration of my participation, I hereby release and covenant not-to-sue Triad Gymnastics, L.C., the Triad officers, and any of their employees or agents, from any and all present and future claims resulting from ordinary negligence on the part of Triad Gymnastics, L.C. or other listed for property damage, personal injury, or wrongful death, arising as a result of my engaging in or receiving instruction in gymnastics, cheerleading, or any other activities incidental thereto, wherever, whenever, or however the same may occur. I hereby voluntarily waive any and all claims resulting from ordinary negligence, both present and future, that may be made by me, my family, estate, heirs, or assigns.

Further, I am aware that gymnastics and cheerleading are vigorous sporting activities involving height and rotation in an unique environment and as such they pose a risk of injury. I understand that gymnastics, cheerleading and related activities always involve certain risks, including but not limited to death, serious neck and spinal injuries resulting in complete or partial paralysis, brain damage, and serious injury to virtually all bones, joints, muscles, and internal organs, and that the mats, pits, and other safety equipment and apparatus provided for my protection, including the active participation of a coach or teacher who will spot or assist in the performance of certain skills, may be inadequate to prevent serious injury. The risk of harm may be limited by all of the safety equipment and trained coaches, but never eliminated. I understand that participation in gymnastics and related activities involves activities incidental to active participation in gymnastics, including moving from event to event, conditioning, stretching and other activities which may leave me vulnerable to the reckless actions of other participants who may not have complete control over their actions or who may not see other students in the gym. I am voluntarily participating in this activity with knowledge of the risks involved and hereby agree to accept any and all inherent risks of property damage, personal injury, or death.

I further agree to indemnify and hold harmless Triad Gymnastics and all other listed for any and all claims arising as a result of my engaging or receiving instruction in Triad Gymnastics, L.C. activities incidental thereto, whenever, wherever, or however the same may occur.

I understand this waiver is intended to be as broad and as inclusive as permitted by the laws of the state of Iowa and agree that if any portion is held invalid, the remainder of the waiver will continue in full legal force and effect. I further agree that the venue for any legal proceedings shall be within the state of Iowa.

I affirm that I am of legal age and am freely signing this agreement. I have read this form and fully understand that by signing this form, I am giving up legal rights and/or remedies which may be available to me for the ordinary negligence of Triad Gymnastics, L.C. or any person listed above.

Parent's Signature _____

Date _____

Athlete's Name _____

Athlete's Signature _____

Date _____

(if over 18 year of age.)

HEALTH HISTORY & MEDICAL RELEASE FORM

Triad Gymnastics

2009-2010

GYMNAST'S NAME: _____ **D.O.B.** _____

Date of last physical exam: _____ **Blood type:** _____

Family Physician: _____ **Phone:** _____

Preferred Hospital: _____

Health History (check all that apply)

___ **Frequent ear infections**

___ **Heart defect / disease**

___ **Convulsions**

___ **Diabetes**

___ **Bleeding/clotting disorders**

___ **Hypertension**

___ **Mononucleosis**

___ **Psychiatric treatment**

Date of last tetanus _____

Diseases (check all that apply)

Chicken pox Measles Asthma
 German measles Mumps

Allergies (check all that apply)

Hay Fever Ivy poisoning, etc.
 Insect stings Penicillin
 Other drugs (if yes, please specify: _____)

Other medical conditions to which Triad staff should be alerted (specify)

Authorization for Treatment
Important- This must be completed for participation

This health history is correct so far as I know. I hereby give permission to the medical personnel selected by Triad Gymnastics staff to use appropriate procedures to aid my daughter, _____ to prevent further injury and/ or death. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Triad Gymnastics, L.C. to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of facility.

Signature of parent or guardian: _____ Date: _____

Competitive Team Program Registration
Form; 2009-2010

Triad Gymnastics, L.C.

Gymnast's Name _____

D.O.B. _____ Home Phone: _____ Grade: _____

Name & City of School: _____ Dismissal Time: _____

Home Address: _____
Street City State Zip

Guardian's Name(s): _____ **Relationship** _____

Home e-mail address (for team news): _____

Other E-mail addresses: _____

Mother's Employer: _____ Position: _____

Mother's Work #: _____ Mother's Cell #: _____

Father's Employer: _____ Position: _____

Father's work #: _____ Father's Cell #: _____

Emergency Contacts – to be used if above guardians cannot be reached:

Name of emergency contact relationship to athlete phone #

Name of emergency contact relationship to athlete phone #

Do we have your permission to distribute your name, address, phone number, and e-mail address to other team members? _____ yes _____ no

Hospital and Physician Reference

Triad Gymnastics 2009-2010

CHILD'S NAME: _____

GUARDIAN'S NAMES: _____

FULL ADDRESS: _____

STREET

CITY

STATE

ZIP CODE

HOME PHONE: Mom _____
Dad _____

WORK PHONE: Mom _____ Dad _____

CELL PHONE: Mom _____ Dad _____

PREFERRED PHYSICIAN: Name _____

Phone _____

PREFERRED HOSPITAL: _____

Do you carry family medical/hospital insurance? ____ Yes ____ No

If so, indicate: Carrier _____

Group or policy # _____

ANY ADDITIONAL INFORMATION: _____
