WELCOME TO ATHLETE'S ADDICTION STRENGTH & SPEED

****If under 18 years of age, parent/guardian must complete****

Participant Name: _____ Participant Phone Number: _____
Participant Email Address: _____ T-Shirt Color: _____ Size:_____
Social Media Handles: _____
Paid By: _____ Relationship to Client: _____
Responsible Party Phone Number: _____
Responsible Party Email Address: _____
Billing Address: _____City _____ State: ____ Zip: _____
Participant DOB: _____ Gender: _____ Allergies: _____
Insurance Carrier: _____ Policy Number: _____
Primary Physician Name and Number: _____
Significant Medical Information: _____

LIABILITY WAIVER

I, the undersigned, do hereby acknowledge that the use of Athlete's Addiction Strength and Speed, Complete Game Sports, United Sportsplex, and additional Athlete's Addiction Strength and Speed Facilities, services, equipment or premises involves risk of injury to my person and my property, and that as a condition to use of the facility, I assume full responsibility for such risks. I hereby indemnify and hold harmless Athlete's Addiction Strength and Speed, Complete Game Sports, United Sportsplex, and additional Athlete's Addiction Strength and Speed Facilities, its agents, related entities and employees, from all liability to me, my heirs and assigns for any loss of damage to me, and forever give up any claims therefore on account of injury to my person or property.

SIGNATURE:_____ DATE: _____

MEDICAL TREATMENT AUTHORIZATION FORM FOR MINOR & ADULT CLIENTS

This form grants temporary authority for AA/AASS to provide and arrange for medical care in the event of an emergency.

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for Athlete's Addiction/ Athlete's Addiction Strength & Speed Staff (hereafter "Designated Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.
It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

SIGNATURE: _____ DATE:_____

PHOTO/VIDEO WAIVER

Athlete's Addiction/ Athlete's Addiction Strength & Speed likes to capture photos or videos as part of our instructional program, as well as a way to share these activities with our community. We need your permission to photograph you or your child for use on our company's media outlets. You may opt out at any time. By signing below you give our staff permission to photograph/video you or your child to use in our company's media outlets.

SIGNATURE _____ DATE: _____

ATHLETE'S ADDICTION STRENGTH AND SPEED

Health Questionnaire for All Clients

**** If under 18 years of age, parent/guardian must complete****

Name of Participant:_____ **DOB:** _____

Parent/Guardian Name: _____ **Email:** _____

Emergency Contact: _____ **Phone Number:** _____

As you are to be a participant in these workout sessions, please complete the following physical activity readiness questionnaire.

	YES	NO
1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?	_____	_____
2. Do you ever experience chest pain during physical activity?	_____	_____
3. Do you ever lose balance because of dizziness or do you ever lose consciousness?	_____	_____
4. Do you have a bone or joint problem that could be made worse by a change in your physical activity participation?	_____	_____
5. Do you have uncontrolled asthma (i.e. asthma that is not easily controlled by an inhaler)?	_____	_____
6. Is your doctor currently prescribing any medication for your blood pressure or heart condition?	_____	_____
7. Do you know of any other reasons why you should not undergo physical activity? This might include diabetes, a recent injury or serious illness.	_____	_____

I _____ declare that the above information is correct at the time of completing this questionnaire. I have discussed my medical issues with my physician and am cleared for physical activity.

SIGNATURE: _____ **DATE:** _____

THANK YOU FOR TRAINING WITH US!

PLEASE LET US KNOW HOW WE CAN MAKE YOUR EXPERIENCE MORE ENJOYABLE!