I hereby release and discharge The Academy of Sports Performance LLC (ASP), its corporators, trustees, employees, students, and agents from any and all costs, liability and expense for personal injury, fatal or otherwise in any way related to the physical training and screening program. I also accept complete responsibility for requesting exercise and assistance. I also understand that any exercise carries with it the possibility for certain changes during exercise. These changes include but may not be limited to abnormal blood pressure, fainting, disorders of heartbeat, muscle strains, or muscle soreness. I hereby acknowledge and accept these risks. All questions have been answered to my satisfaction.

By signing this document, I 1) expressly represent that I am in good health and capable of full participation in rigorous physical activity; 2) agree to assume all risk of personal injury while attending and participating in this program; and 3) acting for myself, my heirs, personal representatives, and assigns, I release ASP, and any of its staff from any loss or liability whatsoever for any accident or injury, fatal or otherwise, which may result directly or indirectly from my involvement with this program. As the parent or legal guardian of the child participating in this program, I indemnify and hold harmless ASP against any future claims.

It is the policy that payment arrangements (those programs that require payment) for participation are made at or prior to time of signing this document. If during the course of this program you must terminate your participation due to injury, illness or family emergency, with written documentation from a licensed physician stating that you can no longer participate at that time, you will receive a prorated refund against sessions not already attended prior to the reason for termination. Missed sessions due to non-medical reasons cannot be made up and will not be refunded.

Participant Information

First Name _____ Last Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Email Address _____

Participant Signature (if over 18) **X** _____ Date _____

Parent or Legal Guardian Name (if under 18) _____ Relationship _____

Parent or Legal Guardian Signature **X**_____ Date _____

If you/your child is recovering from an injury and you'd like us to be able to speak with any other healthcare professionals (Dr, PT, ATC, etc.), please sign below:

Release of Medical Records

I authorize ASP and any treating physician/trainer to release any and all information related to the care and treatment of the above-mentioned patient. I further authorize the release, to the extent necessary, of information from my child's medical record to appointees of ASP's medical staff, its allied health professionals, employees, and other agents as well as to accrediting and licensing/regulation entities who have, in turn, agreed to keep such information confidential, for the purpose of reviewing or auditing the performance of ASP, its medical staff, it's allied health professionals, its employees, and or its agents otherwise assisting ASP in either the rendering of medical care/and or the administration of ASP.

Participant, Parent, or Legal Guardian Signature **X**_____ Date _____