

Play Hard / Recover Fast



CONSENT, WAIVER AND RELEASE

Participant Name: _____ Age _____
Print Full Name

Program: _____ Dates _____

I/We the undersigned, hereby expressly and affirmatively state that I wish to participate in the OSU Sports Medicine Program _____

for the period in the dates mentioned above:

It is agreed that I/We will assume all risks associated with watching and/or participating in program activities, including, but not limited to bodily injury, and that this assumption is acknowledged, approved, and agreed to as indicated by the signature hereto:

I/We hereby certify that I/We am physically able to participate in the OSU Sports Medicine Program designated above and that I/We know of no physical impairments which would in any manner limit my participation in such a program.

I/We hereby grant permission for physicians, dentists, other licensed health care providers and their designees employed by the The Ohio State University Medical Center and The Ohio State University to administer outpatient medical, surgical, or dental services as appropriate, or necessary antigens or other injections, to perform emergency procedures as necessary or to refer to duly licensed medical personnel when indicated.

In consideration for participation in the above activity, I/We, for myself, my executors, administrators, and assigns, do hereby release and forever discharge The Ohio State University, The Ohio State University Medical Center, and its Board of Trustees, its respective entities, administrators, faculty members, employees, agents, physicians, and students from any claims that I/We might have myself with regard to damages, demands, or any actions whatsoever, including those based on negligence or failure to supervise, in any manner arising my participation in this activity. I/We also hereby agree to save, hold harmless, and indemnify The Ohio State University, The Ohio State University Medical Center, its Board of Trustees, and/or its respective entities, administrators, faculty members, employees, agents, physicians, and students against any and all claims, including claims of negligence or failure to supervise, which I/We might bring against them as a result of my participation in the above activity. I/We recognize that this Release means that I/We am giving up, among other things, rights to sue the Medical Center ,University or its Board of Trustees, its respective entities, administrators, faculty members, employees, agents, physicians or students for injuries, damages or losses that I/We may incur.

X _____
Participant Signature – Read above and sign here (Date)

X _____
Parent/Guardian Signature (Date)

EMERGENCY MEDICAL INFORMATION

NAME _____
Parent/Guardian

PHONE (Home) _____ (Work) _____ (Cell) _____

ALTERNATE EMERGENCY CONTACT _____

PHONE (Home) _____ (Work) _____ (Cell) _____