TWU SPARTAN ATHLETICS TRYOUT PARTICIPANT WAIVER

READ this CAREFULLY as YOU are signing an IMPORTANT DOCUMENT! ☐ **Initial here**

Participation in athletic activities and the travel to and from these activities involves the ***risk of personal injury***. The use of equipment, facilities, and premises of Trinity Western University (the "University"), and other institutions by persons participating in athletics shall constitute ***acceptance of that risk*** regardless of the nature of injury. Trinity Western University, its officers, governors, directors, employees, agents, student workers, volunteers and their heirs, executors, administrators, successors, and assigns (hereafter defined as "TWU") shall not be liable for any causes of action, suits, injury, claims, loss, damages, costs and expenses of any nature or kind whatsoever, whether in law or in equity, including but not limited to, injuries sustained or suffered by persons participating in athletics or recreation activities at the University, whether caused directly or indirectly by the negligence or fault of TWU, and the participating athlete hereby waives any such claim. Where the parent or guardian of the participating athlete has consented to the participation of the athletic representative by signing this registration form, the parent or guardian hereby agrees to waive any claim against TWU, which the parent or guardian may have for any and all causes of action, suits, injury, claims, loss, damages, costs and expenses of any nature or kind whatsoever, whether in law or in equity, including but not limited to, injuries sustained by the participating athlete and agrees to indemnify and save harmless TWU from any such claims.

W A R N I N G Any participant with known physical conditions that may be aggravated by participation in this sport (examples: epilepsy, heart conditions, joint problems, a state of poor physical condition, etc.) should check with their physician before participating. TWU, Canada West and the Canadian Interuniversity Sports (CIS) are not responsible for pre-event screening of participant and/or injuries incurred during the event.

Pursuant to the Freedom of Information and the Protection of Privacy Act of British Columbia (1994), I hereby authorize and direct you to release to TWU, Canada West, and the CIS, information concerning my academic records to confirm eligibility requirements in order to compete. You may also use information to assist in the annual awards selection process for TWU, Canada West and the CIS.

Media Release: I also hereby authorize and allow the University to ***release information and news*** about my athletic and academic student achievements to the local, provincial, and my hometown media**.**

☐ **Initial here**

Out of Country Athletes: I understand that I must obtain and keep current British Columbia Health Insurance (BC-MSP). ☐ **Initial here**

Anti-Doping Policy: I acknowledge that the CIS Anti-Doping Policy has been made available to me and understand that it is my responsibility to comply with the guidelines contained in the Anti-Doping Policy. ☐ **Initial here**

Sports Medicine Treatment Consent

ATHLETE'S NAME: _____ **SPORT:** _____

I hereby grant permission to the team physician(s) and/or campus physician(s), and such other persons, including, but not limited to physicians, athletic therapists, physiotherapists, chiropractors, massage therapists, psychologists, nutritionists, student therapists, coaches, strength/conditioning coaches, and such other persons deemed by Trinity Western University appropriate for maintaining the health and well-being of its campus and who form part of their sports medicine team (hereafter defined as the "Sports Medicine Team"), in addition to those professional personnel designated by them, including the athletic therapy staff, Sports Medicine Team, emergency medical personnel and other relevant persons to treat: _____ (me/my son/daughter/dependent). This permission includes emergency surgery and admission to the hospital as deemed necessary in addition to drugs, therapeutic modalities, and rehabilitation exercises used as part of treatment.

I understand that failure to provide an accurate health history or report injuries to the University or the Sports Medicine Team may void the University's responsibility. The University reserves the right, in its absolute discretion, to withhold any athlete from participating in intercollegiate sports.

I recognize that participation in intercollegiate sport tryouts, practices and competitions is highly competitive, demanding physically, AND THAT A RISK OF INJURY IS PRESENT. The University will take reasonable precautions to safeguard health and safety, but I realize that serious and potentially debilitating or fatal injuries can and do occur.

Athlete Signature_____ **Date** _____

Parent Signature _____ **Parent's Printed Name**:_____ **Date** _____
(Required if athlete is under 19 years old)

Athlete Informed Consent to Allow Information Sharing Amongst the Sports Medicine Team

Members of the medical team will be meeting and/or discussing on a regular basis how to best address health concerns and performance of Spartan athletes. Members of the Sports Medicine Team include (but may not be limited to) physicians, athletic therapists, physiotherapists, chiropractors, massage therapists, psychologists, nutritionists, student therapists, coaches, and strength/conditioning coaches. During the course of such discussions, the medical team may need to share confidential information about a Spartan Athlete amongst its members. The information that is shared is generally restricted to only that which is required to allow the rest of the Sports Medicine Team understand the status of an athlete within the area of expertise that member provides to the medical team. Sharing of information may be verbal, in writing, or electronic. All information that is shared is held in the strictest confidence by all members of the Sports Medicine Team.

In signing this consent, you state that you have read and understand the purpose for which the Sports Medicine Team members may share confidential information about _____ (me/my son/daughter/dependent) and that you consent to the sharing of such information about _____ (me/my son/daughter/dependent). You may withdraw this consent at any time by providing written notice to Natalie Ghobrial (Head Athletic Therapist).

CONSENT

I have read the above information and understand the purpose for which the Sports Medicine Team members may share confidential information about _____ (me/my son/daughter/dependent). I give consent to the Sports Medicine Team members to share confidential information about _____ (me/my son/daughter/dependent).

_____	_____	_____
Athlete Name (print)	**Athlete Signature**	**Date**
_____	_____	_____
Parent Name (print)	**Parent Signature**	**Date**

(Required if athlete is under 19yrs old)

Tryout/Practice Medical Form

GENERAL INFORMATION:

Sport:_____

Family Name: _____ **Given Name:**_____

D.O.B. (dd/mm/yyyy):_____ **Health Card # & Province:** _____

Local Address: _____
Street **City** **Prov** **Postal Code**

Permanent Address: _____
Street **City** **Prov** **Postal Code**

Local phone #:_____ **E-mail:**_____

Family Doctor's Name: _____ **Phone #:** _____

MEDICAL HISTORY:

[ ] Y [ ] N Allergies: medications, foods, insects: _____

[ ] Y [ ] N Do any major illnesses/diseases (cancer, heart disease) run in your family? **Who? What?**

_____

[ ] Y [ ] N Other than accidents and injury has any family member died suddenly or otherwise at <50 years of age due to heart disease in one or more relatives? (eg Heart attack) **If yes, elaborate:** _____

_____

[ ] Y [ ] N Disability from heart disease in a close relative < 50 years of age**?** _____

_____

[ ] Y [ ] N Have you heard of any family members with a serious heart problem at an early age such as: Hypertrophic Cardiomyopathy or DC, long QT syndrome or other channelopathies, Marfan Syndrome or clinically important arrhythmias? _____

_____

[ ] Y [ ] N Do you take any prescription or non-prescription medication (i.e. Herbal remedies, advil/ibuprofen, creatine, anabolic steroids, laxatives, water pills…)? **What?** _____

_____

[ ] Y [ ] N Are you currently under a doctor's care for any medical conditions? **What?** _____

_____

[ ] Y [ ] N Have you ever been advised for medical reasons not to participate in certain sports? **If yes, elaborate:**

_____

[ ] Y [ ] N Have you ever been hospitalized overnight or longer? **When? Why?** _____

_____

***Please read carefully and answer fully. Respond to the following with a 'P' (previous), 'C' (current), or leave blank (no). Do you or have you ever had:** (please elaborate in the space provided below).

	HEAD		10. low blood pressure		**HEAT DISORDERS**		**OTHER CONDITIONS**
	1. frequent headaches		11. unexplained syncope/fainting		20. dehydration problems		29. rheumatic fever
	2. concussion		12. chest pain with exercise		21. heat stroke/exhaustion		30. infectious mononucleosis
	3. dizziness with exertion		13. heart disease		22. excessive thirst		31. diabetes
	4. fainting with exercise		14. heart palpitations		23. frequent muscle cramps		32. unintended weight loss
	5. recurring blackouts		15. sickle cell disease		**DIGESTIVE / ORGANS**		33. HIV positive
	6. meningitis		16. poor circulation		24. blood in urine		34. bleeding disorder
	7. convulsions / seizures		**RESPIRATORY**		25. blood in stool		35. burner/stinger
	CARDIOVASCULAR		17. shortness of breath		26. hepatitis		
	8. heart murmur		18. asthma/wheezing		27. enlarged/ruptured spleen		
	9. high blood pressure		19. collapsed lung		28. single/missing organs		

Please elaborate on any conditions that you marked with a 'P' or a 'C'

Condition #	**Date(s)** – year, month	**Comments** – include severity, duration, treatment etc.

Concussion	**Date(s)**	**Unconsciousness?**	**Duration of symptoms**	**MRI/CT/Neuropsych**

I _____, certify that the above information is true, and I have made a full and complete disclosure concerning any and all illnesses, allergies, injuries, physical characteristics and conditions regarding my medical information/history.
The University reserves the right, in its absolute discretion, to withhold any individual from participating with the intercollegiate team.
I give the Sports Medicine Team and the Spartan Athletics Staff consent to inform my Emergency Contact(s) should I be involved in a medical emergency. I consent to the release of all information from this medical history and exam to the TWU Athletics Therapists, Sports Medicine Team, Team coaches, Emergency Medical Personnel and any other relevant persons who may require this information. I also understand that I am NOT covered by TWU Sport Accident Insurance during this tryout/participation period.

_____ _____

Student-Athlete Signature **Date**

_____ _____

Parent's Signature (Required if athlete is under 19 years old) **Date**