

# Consent Form for SportsMetrics/Core Exercise Training Program

Participant Name (Please Print): \_\_\_\_\_

## Instructions:

- Please sign in each session of the program.
- Give 100% effort during each workout. Your cooperation and compliance to the program determines your benefit.
- Be Safe! If you are unsure about any activity, please ask instructor. Report any problems to instructor.

## Participant Consent Information:

In becoming a participant in this program, my guardian and I understand and agree as follows:

\* There exists the possibility of circumstances occurring during the program such as, but not limited to, abnormal blood pressure, muscle strain, joint inflammation, and fainting, irregular heart rate. It is the responsibility of the participant to report any abnormal health issues and remove herself from the activity immediately. Every effort will be made to prevent the occurrence of such incidence.

\* Participants will cooperate with the program's instructor and not deviate from the instructions given pertaining to the exercise. Individuals who are disruptive will be expelled from the program without reimbursement.

\* Participants will not be allowed to attend a workout session when under the influence of drugs or alcohol. If a participant is suspect to such an offense they will be expelled from the program without reimbursement.

I hereby agree to release, discharge and forever hold harmless Empire Volleyball Club and Santa Rosa Orthopaedics, Inc. (and each and everyone of its affiliated companies, officers, directors, employees, agents and representatives) from any and all claims which I might now or hereafter have with respect to the program I am consenting to herein.

I acknowledge that I have read this form in its entirety, and that I understand and accept the risks, rules and regulations set forth. I consent to participate in this program.

_____	_____	_____	_____
PARTICIPANT'S SIGNATURE	DATE	PARENT'S SIGNATURE	DATE
		(If under 18 years of age)	

LIST PAST MEDICAL HISTORY: Primary Care Physician: \_\_\_\_\_ Tel: \_\_\_\_\_

**Date, type, and location of Injury(s)** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Return this form to:  
**Santa Rosa Orthopaedics and Rehabilitation**  
131B Stony Circle, Suite 2000  
Santa Rosa, CA 95401  
(707) 522-5405