Read and Keep This Form for Your Files

3sneaks
health and sport, LLC

MEDICAL FORMS PACKET

PLEASE RETURN ALL FORMS THAT STATE "SIGN AND RETURN" ALONG WITH THIS PAGE, DATED AND SIGNED WHERE APPROPRIATE ***TWO WEEKS PRIOR TO YOUR CLINIC START DATE*** TO THE FOLLOWING ADDRESS:

Attn: Brooke Whitney
3sneaks health & sport, LLC
15948 NE 83rd Way
Redmond, WA 98052

*Note: This form is required prior to participation in **3 sneaks** Clinics. Participation will not be permitted until this form has been completed and signed and is on file with the **3 sneaks** Clinic. If preferred, scan and email the signed forms to 3sneaks@gmail.com.*

REQUIRED CAMP MEDICAL FORMS

The 3 sneaks health & sport, LLC staff wishes to welcome your child as a sports clinic participant. Every clinic carries with it some degree of risk to the participant because of the vigorous nature of the activities.

To facilitate this care, we are requesting that you complete a number of health status and medical release forms. Your child will not be permitted to participate in any activities until all forms are completed and are on file with the clinic supervisors. The forms are briefly described below for your review and subsequent completion on the following pages:

- **MEDICAL HISTORY**
  Your child's personally identifiable health information will not be disclosed unless you sign the appropriate authorization form included in this packet. It is important to understand that our staff will respect the privacy of your child's health information, release only the minimum necessary to protect her health and safety, and take appropriate measures to ensure the confidentiality of medical information.

- **SELF-ADMINISTERING OF MEDICATION**
  In order for your child to carry and self-administer medication during 3 sneaks clinic activities, you must affirm and agree that: (1) your child has been instructed in the proper use of the medication and is physically, mentally, and behaviorally capable of administering the medication on their own without clinic personnel supervision; (2) your child has an adequate supply of the medication for the duration of the clinic and has the ability to properly store and secure the medication; (3) your child will use the medication only as prescribed by a physician and/or according to dosage instructions and will not share or otherwise provide medication to any other camper; and, (4) your child understands and agrees that failure to abide by this agreement constitutes a violation of clinic rules that will result in disciplinary action, up to and including removal from clinic.

■ **SPORTS CLINIC ASSUMPTION OF RISK/RELEASE AND INDEMNIFICATION AGREEMENT**

With your signature on this form, you fully recognize that there are dangers and risks to which your child may be exposed by participating in the clinic. We make every effort to increase the participant's knowledge concerning rules and practices being employed to minimize risk of injury or illness while pursuing the many benefits of clinic activities. Moreover, as injury/illness risks are identified, steps are taken to minimize the causes, where possible. We teach the latest in skill acquisition and technique as well as implement preventative injury measures such as warming up prior to vigorous activity, stretching, and fluid replacement, realizing that all of these measures have the potential to lower risk of injury. Even with these efforts, a certain number of injuries/illnesses will occur and you accept responsibility for any medical conditions that may result from your child's participation in clinic activities.

Print, Sign and Return This Form

3sneaks
health and sport, LLC

MEDICAL HISTORY

PLEASE PRINT USING BLACK INK

CLINIC LOCATION: _____

PARTICIPANT INFORMATION

NAME: _____
First *Middle* *Last*

HOME ADDRESS: _____
Street Address

_____
City *State* *Zip*

AGE: _____ **DATE OF BIRTH**: _____

FATHER/GUARDIAN NAME: _____

ADDRESS: _____

PHONE: *Home* (_____) _____ *Work* (_____) _____ *Cell* (_____) _____

MOTHER/GUARDIAN NAME: _____

ADDRESS: _____

PHONE: *Home* (_____) _____ *Work* (_____) _____ *Cell* (_____) _____

OTHER/EMERGENCY CONTACT PERSON NAME: _____

PHONE: *Home* (_____) _____ *Work* (_____) _____ *Cell* (_____) _____

FAMILY PHYSICIAN: _____ PHONE: (_____) _____

INSURANCE COMPANY: _____ ID NUMBER: _____

MEDICAL HISTORY (Please use back of this sheet if necessary)

DATE OF LAST TETANUS BOOSTER: _____

Is the participant under the care of a provider for a medical and/or psychological problem? NO YES
If yes, please explain: _____

Is the participant taking medication prescribed by a health care provider? NO YES
If yes, please explain: _____

ALLERGIES ⇒ If yes, please list the allergy and provide additional information if necessary.

_____

_____

Date of Physical Examination **(must have been completed within the last 12 months):**

_____

Print, Sign and Return This Form – Only if Applies

SELF ADMINISTERING OF MEDICATION

3 sneaks will not supply over-the-counter or prescription medication to clinic participants. For this participant to carry and self-administer medication during 3 sneaks sponsored sports clinic activities, this form must be completed by an authorizing parent or legal guardian.

PARTICIPANT NAME: _____

CLINIC LOCATION: _____

NAME OF MEDICATION(S): _____

_____

REASON FOR TAKING: _____

_____

As the parent/guardian of the above named participant,

- I affirm and agree that my child has been instructed in the proper use of the medication and is physically, mentally, and behaviorally capable of administering the medication on his/or her own without clinic personnel supervision. I also affirm that they have an adequate supply of the medication for the duration of the clinic, and have the ability to properly store and secure the medication.

- I affirm that my child understands and agrees that they will use the medication only as prescribed by a physician and/or according to dosage instructions, and will not share or otherwise provide medication to any other person while at the clinic.

* If after the participant has self-administered an over-the-counter medication there is an adverse reaction, I give my permission to the 3 sneaks clinic personnel to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

- I agree that my child understands that failure to abide by this agreement constitutes a violation of clinic rules that will result in disciplinary action, up to and including removal from the clinic.

Parent/Guardian Signature _____ Date _____

Participant's Signature _____ Date _____

Print, Sign and Return This Form

SPORTS CLINIC ASSUMPTION OF RISK/RELEASE AND INDEMNIFICATION AGREEMENT

PARTICIPANTS NAME: _____

CLINIC LOCATION: _____

I am the Parent/Guardian of the above-named Participant who is under eighteen years of age and am fully competent to sign this Agreement.

RELEASE OF LIABILITY: I hereby release and discharge, indemnify and hold harmless 3 sneaks health & sport, LLC, and their employees, and any other persons or entities acting on the behalf, and the successors and assigns for any and all of the aforementioned persons and entities, against all claims, demands, cost and expenses, and causes of action whatsoever, either in law or equity, arising out of or in any way connected with any property loss and/or bodily injury and/or disability, arising form my child's participation in the sports clinic activities. I further agree to indemnify and hold harmless 3 sneaks and its employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from Participant's negligent or intentional act or omission while participating in the described Activity.

CONSENT FOR TREATMENT: I hereby give my permission to a clinic certified athletic trainer to supervise on-site first aid for minor injuries. In the absence of a certified athletic trainer, I give permission to 3 sneaks staff to supervise on-site first aid for minor injuries. In the event of injury such as broken limb, sprain, contusion, laceration, concussion, etc., or illness requiring medical diagnosis or treatment, I hereby give my consent for sports clinic staff to secure the proper medical care; including transportation and hospitalization, if necessary. Every attempt will be made to contact the parent or guardian to inform you of the need for any medical attention beyond minor first aid, if necessary.

PHYSICAL EXAMINATION WITHIN ONE YEAR: I certify that within the past 12 months my child has had a physical examination by a physician and that he/she is physically able to participate in the sports clinic activities. Also, my child has no known physical infirmities which could be worsened or aggravated by participation and I declare him/her physically fit and in good medical condition to engage in all clinic activities.

ASSUMPTION OF FINANCIAL RESPONSIBILITY: I hereby acknowledge that I am responsible for medical charges incurred during sports clinic participation. I further understand that the sports clinic carries an excess medical insurance policy for sports injuries to the participant that may result from clinic activities. Clinic insurance has limits and exclusions and any secondary charges not covered under this plan will be my responsibility. This policy may only be utilized after my primary insurance company has processed the claims and issued an explanation of benefits.

I acknowledge that I have provided accurate medical information for the participant listed on this form. I also acknowledge that I have read this release of liability, consent for treatment, and express assumption of financial responsibility agreement and fully understand it.

PRINT NAME: _____ **DATE**: _____

SIGNATURE: _____

RELATIONSHIP TO PARTICIPANT: _____