



## **ATHLETE REGISTRATION**

### *Registration Forms Instructional Cover Letter*

#### **Dear Special Olympics Washington Athlete:**

Welcome to Special Olympics Washington! Through the power of sports, our participants find joy, confidence and fulfillment — on the playing field and in life. Whether you are new to Special Olympics Washington or have been involved for years, we are excited you are part of the movement!

To register or re-register as a Special Olympics athlete, please complete the enclosed forms and provide them to your coach. All forms are required to participate:

- REGISTRATION FORM** (page 1): This form asks for contact and other important information related to the athlete. If you do not yet have a team, please indicate that you need one in the 'Program-Team' line on the registration form.
- MEDICAL FORM** (page 2-4): This form is designed to identify health concerns that are more common among people with intellectual disabilities and clear an athlete to participate. Please fill out the Health History section on pages 1 and 2. If you do not understand any parts of the form, you may leave those parts blank to be discussed during the exam. The Physical Exam section on page 3 should be filled out and signed by a licensed medical professional (for example, Physician, Registered Nurse Practitioner, or Physician Assistant).
- RELEASE FORM** (page 5): This form goes over some important details about Special Olympics Washington participation.
- COMMUNICABLE DISEASE (COVID) WAIVER** (page 6): This waiver was added during COVID and is required to participate.

If you have any additional questions or need clarification on any of the items on the forms, please contact us:



# ATHLETE REGISTRATION FORM

State Special Olympics Program: SW - PIERCE COUNTY Local Area/Delegation: SOUND ATHLETICS

Are you a new athlete to Special Olympics or Re-Registering?  New Athlete  Re-Registering

ATHLETE INFORMATION		
First Name:	Middle Name:	
Last Name:	Preferred Name:	
Date of Birth (mm/dd/yyyy):	<input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Other Gender Identity
Race/Ethnicity: <input type="checkbox"/> Prefer not to answer		
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Asian American	<input type="checkbox"/> More than one race
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
<input type="checkbox"/> White or Caucasian	<input type="checkbox"/> Hispanic or Latinx	
Language(s) Spoken in Athlete's Home (Optional): Check all that apply		
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please list):		
Street Address:		
City:	State:	Zip Code:
Phone:	E-mail:	
Sports/Activities:		
Athlete Employer, if any (Optional):		
Does the athlete have the capacity to consent to medical treatment on his or her own behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No		
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)		
Name:		
Relationship:		
<input type="checkbox"/> Same Contact Info as Athlete		
Street Address:		
City:	State:	Zip Code:
Phone:	E-mail:	
EMERGENCY CONTACT INFORMATION		
<input type="checkbox"/> Same as Parent/Guardian		
Name:		
Phone:	Relationship:	
PHYSICIAN & INSURANCE INFORMATION		
Physician Name:		
Physician Phone:		
Insurance Company:	Insurance Policy Number:	
Insurance Group Number:		

# Athlete Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)



Athlete First & Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Athlete Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Female  Male  Other Prefer

STATE PROGRAM: SW - PIERCE COUNTY

E-mail: \_\_\_\_\_

### ASSOCIATED CONDITIONS - Does the athlete have (check any that apply):

- Autism  Down Syndrome  Fragile X Syndrome  
 Cerebral Palsy  Fetal Alcohol Syndrome  
 Other Syndrome, please specify: \_\_\_\_\_

### ALLERGIES & DIETARY RESTRICTIONS

- No Known Allergies  
 Latex  
 Medications: \_\_\_\_\_  
 Insect Bites or Stings: \_\_\_\_\_  
 Food: \_\_\_\_\_

### ASSISTIVE DEVICES - Does the athlete use (check any that apply):

- Brace  Colostomy  Communication Device  
 C-PAP Machine  Crutches or Walker  Dentures  
 Glasses or Contacts  G-Tube or J-Tube  Hearing Aid  
 Implanted Device  Inhaler  Pacemaker  
 Removable Prosthetics  Splint  Wheel Chair

List any special dietary needs: \_\_\_\_\_

### SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play: \_\_\_\_\_

Has a doctor ever limited the athlete's participation in sports?

- No  Yes *If yes, please describe:* \_\_\_\_\_

### SURGERIES, INFECTIONS, VACCINES

List all past surgeries: \_\_\_\_\_

Does the athlete currently have any chronic or acute infection?

- No  Yes *If yes, please describe:* \_\_\_\_\_

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? *If yes, describe date and results*

- Yes, had abnormal EKG \_\_\_\_\_  
 Yes, had abnormal Echo \_\_\_\_\_

Has the athlete had a Tetanus vaccine in the past 7 years?  No  Yes

### EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any type of seizure disorder  No  Yes

*If yes, list seizure type:* \_\_\_\_\_

*If yes, had seizure during the past year?*  No  Yes

### MENTAL HEALTH

Self-injurious behavior during the past year  No  Yes | Depression (diagnosed)  No  Yes  
Aggressive behavior during the past year  No  Yes | Anxiety (diagnosed)  No  Yes

Describe any additional mental health concerns: \_\_\_\_\_

### FAMILY HISTORY

Has any relative died of a heart problem before age 50?  No  Yes

Has any family member or relative died while exercising?  No  Yes

List all medical conditions that run in the athlete's family: \_\_\_\_\_

# Athlete Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)



Athlete's First and Last Name: \_\_\_\_\_

**HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS**

Loss of Consciousness	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke/TIA	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dizziness during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	Concussions	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headache during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Vision Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chest pain during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Shortness of breath during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Enlarged Spleen	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Irregular, racing or skipped heart beats	<input type="checkbox"/> No <input type="checkbox"/> Yes	Single Kidney	<input type="checkbox"/> No <input type="checkbox"/> Yes	Urinary Discomfort	<input type="checkbox"/> No <input type="checkbox"/> Yes
Congenital Heart Defect	<input type="checkbox"/> No <input type="checkbox"/> Yes	Osteoporosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Spina Bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Attack	<input type="checkbox"/> No <input type="checkbox"/> Yes	Osteopenia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cardiomyopathy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heat Illness	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Valve Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Trait	<input type="checkbox"/> No <input type="checkbox"/> Yes	Broken Bones	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	Easy Bleeding	<input type="checkbox"/> No <input type="checkbox"/> Yes	Dislocated Joints	<input type="checkbox"/> No <input type="checkbox"/> Yes
Endocarditis	<input type="checkbox"/> No <input type="checkbox"/> Yes	If female athlete, list date of last menstrual period: _____			

Describe any past broken bones or dislocated joints (if yes is checked for either of those fields above): \_\_\_\_\_

List any other ongoing or past medical conditions: \_\_\_\_\_

**Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability**

Difficulty controlling bowels or bladder	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Numbness or tingling in legs, arms, hands or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Weakness in legs, arms, hands or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Head Tilt	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Spasticity	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Paralysis	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes

**PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW**

(includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement Name	Dosage	Times per Day	Medication, Vitamin or Supplement Name	Dosage	Times per Day	Medication, Vitamin or Supplement Name	Dosage	Times per Day

Is the athlete able to administer his or her own medications?  No  Yes

Name of Person Completing this Form      Relationship to Athlete      Phone      Email

# Athlete Medical Form – PHYSICAL EXAM

(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)

Athlete's First and Last Name: \_\_\_\_\_

## MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

Height	Weight	BMI (optional)	Temperature	Pulse	O <sub>2</sub> Sat	Blood Pressure (in mmHg)		Vision		
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or better <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A		
in	lbs	Body Fat %	F					Left Vision 20/40 or better <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A		

Right Hearing (Finger Rub) <input type="checkbox"/> Responds <input type="checkbox"/> No Response <input type="checkbox"/> Can't Evaluate <input type="checkbox"/>	Bowel Sounds <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Left Hearing (Finger Rub) <input type="checkbox"/> Responds <input type="checkbox"/> No Response <input type="checkbox"/> Can't Evaluate <input type="checkbox"/>	Hepatomegaly <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
Right Ear Canal <input type="checkbox"/> Clear <input type="checkbox"/> Cerumen <input type="checkbox"/> Foreign Body <input type="checkbox"/>	Splenomegaly <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
Left Ear Canal <input type="checkbox"/> Clear <input type="checkbox"/> Cerumen <input type="checkbox"/> Foreign Body <input type="checkbox"/>	Abdominal Tenderness <input type="checkbox"/> No <input type="checkbox"/> RUQ <input type="checkbox"/> RLQ <input type="checkbox"/> LUQ <input type="checkbox"/> LLQ
Right Tympanic Membrane <input type="checkbox"/> Clear <input type="checkbox"/> Perforation <input type="checkbox"/> Infection <input type="checkbox"/> NA <input type="checkbox"/>	Kidney Tenderness <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/>
Left Tympanic Membrane <input type="checkbox"/> Clear <input type="checkbox"/> Perforation <input type="checkbox"/> Infection <input type="checkbox"/> NA <input type="checkbox"/>	Right upper extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia <input type="checkbox"/>
Oral Hygiene <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>	Left upper extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia <input type="checkbox"/>
Thyroid Enlargement <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>	Right lower extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia <input type="checkbox"/>
Lymph Node Enlargement <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>	Left lower extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia <input type="checkbox"/>
Heart Murmur (supine) <input type="checkbox"/> No <input type="checkbox"/> 1/6 or 2/6 <input type="checkbox"/> 3/6 or greater <input type="checkbox"/>	Abnormal Gait <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Heart Murmur (upright) <input type="checkbox"/> No <input type="checkbox"/> 1/6 or 2/6 <input type="checkbox"/> 3/6 or greater <input type="checkbox"/>	Spasticity <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Heart Rhythm <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/>	Tremor <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Lungs <input type="checkbox"/> Clear <input type="checkbox"/> Not clear <input type="checkbox"/>	Neck & Back Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Right Leg Edema <input type="checkbox"/> No <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+	Upper Extremity Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Left Leg Edema <input type="checkbox"/> No <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+	Lower Extremity Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Radial Pulse Symmetry <input type="checkbox"/> Yes <input type="checkbox"/> R>L <input type="checkbox"/> L>R <input type="checkbox"/>	Upper Extremity Strength <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Cyanosis <input type="checkbox"/> No <input type="checkbox"/> Yes, describe <input type="checkbox"/>	Lower Extremity Strength <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Clubbing <input type="checkbox"/> No <input type="checkbox"/> Yes, describe <input type="checkbox"/>	Loss of Sensitivity <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below

### SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) (Select one)

- Athlete shows **NO EVIDENCE** of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.
- OR
- Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and **must receive an additional neurological evaluation** to rule out additional risk of spinal cord injury prior to clearance for sports participation.

### ATHLETE CLEARANCE TO PARTICIPATE (TO BE COMPLETED BY EXAMINER ONLY)

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please have specialist complete referral **linked here** and return SOWA.

- This athlete is **ABLE** to participate in Special Olympics sports without restrictions.
- This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions. Describe → \_\_\_\_\_
- This athlete **MAY NOT participate** in Special Olympics sports at this time & **MUST** be further evaluated by a physician for the following concerns:
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Concerning Cardiac Exam       | <input type="checkbox"/> Acute Infection                  | <input type="checkbox"/> O <sub>2</sub> Saturation Less than 90% on Room Air |
| <input type="checkbox"/> Concerning Neurological Exam  | <input type="checkbox"/> Stage II Hypertension or Greater | <input type="checkbox"/> Hepatomegaly or Splenomegaly                        |
| <input type="checkbox"/> Other, please describe: _____ |   |  |

### Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Follow up with a cardiologist      | <input type="checkbox"/> Follow up with a neurologist        | <input type="checkbox"/> Follow up with a primary care physician      |
| <input type="checkbox"/> Follow up with a vision specialist | <input type="checkbox"/> Follow up with a hearing specialist | <input type="checkbox"/> Follow up with a dentist or dental hygienist |
| <input type="checkbox"/> Follow up with a podiatrist        | <input type="checkbox"/> Follow up with a physical therapist | <input type="checkbox"/> Follow up with a nutritionist                |
| <input type="checkbox"/> Other/Exam Notes: _____            |  |   |

Signature of Licensed Medical Examiner	Exam Date	Name:	
		E-mail:	
		Phone:	License #:

# ATHLETE RELEASE FORM



I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, words, and biographical information to promote Special Olympics and raise funds for Special Olympics.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
4. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:
  - I have a religious or other objection to receiving medical treatment. (Not common.)
  - I do not consent to blood transfusions. (Not common.)
 (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
6. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.
7. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").
  - I agree and consent to Special Olympics:
    - using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
    - using my contact information for communicating with me about Special Olympics.
  - I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.
  - *Privacy Policy.* Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at [www.SpecialOlympics.org/Privacy-Policy](http://www.SpecialOlympics.org/Privacy-Policy).
8. **Optional Informational Responses.**
  - Please list your current living/housing situation (group home, with family, etc.): \_\_\_\_\_
  - How did you hear about us: \_\_\_\_\_

<b>Athlete Name:</b>	
<b>ATHLETE SIGNATURE</b> (required for adult athlete with capacity to sign legal documents)	
I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.	
<b>Athlete Signature:</b>	<b>Date:</b>
<b>PARENT/GUARDIAN SIGNATURE</b> (required for athlete who is a minor or lacks capacity to sign legal documents)	
I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.	
<b>Parent/Guardian Signature:</b>	<b>Date:</b>
<b>Printed Name:</b>	<b>Relationship:</b>

**WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION AGREEMENT  
FOR COMMUNICABLE DISEASES  
("Agreement") for  
SPECIAL OLYMPICS**

In consideration of being allowed to participate in any way in Special Olympics sports training, competition or fundraising activities, the undersigned acknowledges, appreciates, and agrees that:

1. Participation includes possible exposure to and illness from infectious and/or communicable diseases including but not limited to MRSA, influenza, and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and,
2. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and,
3. I willingly agree to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, I observe and any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and,
4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Special Olympics, Inc, Special Olympics Washington their officers, officials, agents, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("RELEASEES"), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

**I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IF FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.**

Name of Participant: \_\_\_\_\_

Participant Signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

**FOR PARTICIPANTS OF MINORITY AGE (UNDER AGE 18 AT THE TIME OF REGISTRATION)**

This is to certify that I, as parent/guardian, with legal responsibility for this participant, have read and explained the provisions in this waiver/release to my child/ward including the risks of presence and participation and his/her personal responsibilities for adhering to the rules and regulations for protection against communicable diseases. Furthermore, my child/ward understands and accepts these risks and responsibilities. I for myself, my spouse, and child/ward do consent and agree to his/her release provided above for all the Releasees and myself, my spouse, and child/ward do release and agree to indemnify and hold harmless the Releasees for any and all liabilities incident to my minor child's/ward's presence or participation in these activities as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE, to the fullest extent provided by law.

Name of parent/guardian: \_\_\_\_\_

Parent guardian/signature: \_\_\_\_\_

Date signed: \_\_\_\_\_