

GymTriX Team Gymnastics Medical/Liability Release Form

Event Name/Date(s): 2020- 2021 Season (June 2020-June 2021)

Athlete's Full Name: _____

Address: _____

City/State/Zip _____ Home Phone _____

Birth Date: _____ Sex: M F Athlete e-mail _____

Age by December 1st, 2020 _____ Current School: _____

Parent(s)/Guardian Living with Gymnast: _____

Parent Daytime Phone _____ Mom's Cell _____ Dad's Cell _____

Parent E-Mail _____ (most announcements are sent via email)

GymTriX attempt to keep our businesses "in the family" when possible. Is your family involved in a business that could do business with GymTriX? (ex. Gymnastics supplies, athletic wear, office supplies, printing, catering, advertising)

Referred by: _____ (Please only list one.)

Authorization and Release

I authorize GymTriX Inc and its representatives to consent to medical treatment for my child when I cannot be reached to so consent. I also give GymTriX Inc. permission to administer the necessary emergency care to my child to stabilize and/or improve the current injury or condition that my child may have sustained during activities related to GymTriX instruction, practices, or performances. No prior determination to life threatening emergency or danger of serious or permanent injury resulting from treatment need be made under this authorization. Exceptions to this authorization are as follows:

I am fully aware that any activity involving motion, height, or athletic activity creates the possibility of serious injury, and I further agree to hold GymTriX and its staff and officers harmless for any injury or resulting expense(s). I release and discharge all rights and claims against GymTriX, Inc. GymTriX strives to provide the maximum in safety procedures and guidelines, and therefore assume no responsibility for any accidents or injuries that may occur.

Parent/Guardian Signature _____ Date _____

Please list any physical/psychological limitations, injury, or weakness that may affect the athlete:

Any medicines athlete is allergic to:----- _____

Doctor: _____ Phone _____

Medical Insurance Co./Policy # _____

Emergency Contact: _____ Phone _____