Athlete Registration

Name _____ Date of Birth_____

Address _____ City _____ ST___ Zip _____

Home Phone _____ Cell Phone _____ Sex (M/F)____

Emergency Phone and Contact _____

Email Address _____

How did you hear about Athletic Republic? ___coach ___friend ___mailer ___newspaper ___sponsorship ___other_____

School _____ Grade _____ Coach _____

Sports Played _____ Position/Event _____

Have you recently been injured? _____ If yes, explain _____

_____

Are you currently taking any medications? _____ Please list _____

Is there any condition that may limit your participation in a training program? _____
Explain _____

When does your sport begin? _____

_____ _____

Signature Parent/guardian (if under 18)

For Office Use Only

Program _____ Trainer _____

Payment(s) _____Start Date_____ End Date _____

Notification____ Consent____ Med. History____ Permission/Medical Treatment____

Policy/Procedure____ Waiver____ Discipline____ Asthma____ Physical____

Notes _____

Customer Notification Agreement

I understand that I am a customer of Athletic Republic which operates a training center at 150 South Mt. Auburn, Cape Girardeau, MO (the "Training Center") and uses a confidential and proprietary system created by Acceleration Products, Inc. an American company doing business as Athletic Republic™, (Acceleration Products") to train its customer to maximize their full athletic potential (the "System"). As a customer of Athletic Republic, I agree to sign this Notification Agreement.

In consideration of becoming a customer of Athletic Republic, I hereby agree as follows:

1. Unless approved by Athletic Republic, I will not remove any printed information or other materials from the Training Center.

2. While I am a customer of Athletic Republic, and for a period of three (3) years thereafter,

    a. I shall hold and maintain all information relating to the System which I receive from Athletic Republic, in strictest confidence and

    b. I shall not, without the prior written consent of Athletic Republic, and Acceleration Products, directly or indirectly divulge, reveal, report, publish, transfer or otherwise discover any of such information to any person or party for any reason whatsoever.

3. While I am a customer of Athletic Republic, and for a period of three (3) years thereafter, I shall not, without the prior written consent of Athletic Republic, and Acceleration Products, design, develop, promote, advertise, establish, own, operate, lease, maintain, franchise, engage in, be connected with, or have an interest, directory or indirectly, any business or entity which is competitive with the Training Center.

4. This Notification Agreement shall be governed by and construed in accordance with the laws of Missouri.

IN WITNESS WHEREOF, I have executed and delivered this Notification Agreement as of

_____/_____/_____
MM/DD/YYYY

ATHLETE (CUSTOMER)

Signature _____

Printed _____

_____
Parent/Guardian (if customer is under 18 years of age)

Discipline Policy

It is the policy of Saint Francis that athletes are allowed to train and condition in a safe environment. Anything that impedes the safe performance of the Athletic Republic Program at Saint Francis will not be tolerated.

The Athletic Republic Program is designed to condition the athlete to his or her best ability. It is not a camp, or a daycare program. Horseplay or lack of ability to follow instructions that continues past warning will result in forfeit of the day's workout. The athlete's parent will be contacted and the athlete will be picked up from the facility. Three such occurrences will result in immediate dismissal from the program. No refunds will be given for dismissal secondary to disciplinary action.

Saint Francis wants our athletes to be the best they can be. This policy will ensure that the environment is safe from potential accidents related to lack of appropriate behavior while training in the facility.

Signed:

Athlete _____ Date _____

Parent _____ Date _____

Athlete Republic
Certified Trainer _____ Date _____

Informed Consent

My participation in the Athletic Republic Program™ is voluntary and I may withdraw from the evaluation or program at any time. The benefits associated with my participation include information regarding my personal state of fitness and the increase of my physiological knowledge.

I HEREBY CONSENT TO and PERMIT the Athletic Republic Program staff to use my testing data obtained in report or publications, but my identity will not be associated with such reports unless I have given specific permission to do so.

I understand that these evaluation(s) and program participation should not result in physical injury to me. However, I acknowledge the following:

> *In the event of physical injury resulting from the evaluation procedures, equipment usage or equipment testing, initial first aid will be provided. If further medical attention is needed I must look to my own health insurance policies for further medical assistance.*

I understand the Athletic Republic™ Program staff is relying on all information provided by me regarding my medical history and condition before allowing me to participate in any evaluation or training program. I certify the information to be true and correct.

_____ _____

Client Signature

Parent/Guardian/Conservator Signature (if Client is a minor)

Medical History Survey

1. Do you have now or have you had in the past, problems with (check YES or NO for each area listed):

	YES	NO
Headaches Requiring Treatment		
Heart		
Breathing (i.e. asthma)		
Abdominal Pain		
Dizzy Spells / Fainting		
Black Outs		
Eyes (except glasses)		
Hearing or Ears		
Arthritis		
Joint Pain or Swelling		
Knees (i.e. injury, giving out, swelling)		
Spine (Back or Neck)		
Brocken Bones		
Kidneys		
Bladder		
Diabetes		
High Blood Pressure		
Cancer		
Operations or Surgery		
Varicose Veins		
Skin Disorders		
Other Major Injuries		
Drug Allergies		
Eating Disorder		
Allergies		
Numbness or Tingling in Arms, Hands, Legs or Feet		
Skin Rashes		

2. Have you had any problems with the following muscle, tendon, bone or joint areas, with (check YES or NN for each area listed):

	YES	N O
Head		
Neck		
Back		
Chest		
Shoulder		
Upper Arm		
Elbow		
Forearm		
Wrist		
Hand		

	YES	N O
Fingers		
Hip		
Thigh		
Knee		
Skin		
Calf		
Ankle		
Foot		
Toes		

3. If you answered YES to any of items in questions 1 or 2, please provide details:

_____

_____

4. What physical activities have you been doing in the last two months?

_____

_____

_____

5. Have you ever been knocked unconscious and/or had a seizure? _____
   If yes, please provide details:_____

   _____

6. Have you ever had a cervical spine injury? _____
   If yes, please provide details:_____

   _____

7. Are you under a physician's care at the present time? _____
   If yes, please provide details:_____

   _____

   _____

8. Are you taking any medications or drugs at the present time? _____
   If yes, please provide details:_____

   _____

   _____

9. Are you taking any supplements at the current time?_____
   If yes, please provide details:_____

   _____

10. Do you have a permanent handicap or disability?_____
    If yes, please provide details:_____

    _____

    _____

11. Have you ever had any problems during or after exercise such as passing out, dizziness or chest pains?_____
    If yes, please provide details:_____

    _____

    _____

12. Have you ever become ill from exercising in the heat?_____
    If yes, please provide details:_____

    _____

    _____

13. Please provide any other pertinent information not asked on this form.

    _____

RELEASE OF ALL CLAIMS, WAIVER OR LIABILITY AND INDEMNIFICATION AGREEMENT

ACKNOWLEDGEMENT OF RISK AND DANGER AND ASSUMPTION OF RISK

I understand and am aware that the use of the Athletic Republic™ Program facilities and equipment has inherent and unanticipated and unknown risks and dangers that may cause injuries or death. I expressly assume all risk or injury or death that may be sustained during my use of the facilities and equipment, it's officers, director, agents and employees, defects in the facilities and equipment, the negligence of others and my own negligence of misuse.

_____/_____
Initial – If minor, parent/guardian/conservator also initial

RELEASE COVENANT AND PROMISE NOT TO SUE

In consideration of being permitted to use the Athletic Republic™ Program facilities, services and equipment, I hereby release, acquit and discharge this facility, its successors and assigns, and it's offices, director, agents, and employees of and from all claims and liability of any kind which agree that I will not sue or commence any action of any kind against Athletic Republic™ Program, its successors and assigns and its officers, directors, agents, or employees.

_____/_____
Initial – If minor, parent/guardian/conservator also initial

INDEMNIFICATION AGREEMENT

In consideration of being permitted to use the Athletic Republic™ Program facilities, services, and equipment, I agree to indemnify and hold harmless this facility, its successors and assigns, and its officers, director, agents, and employees of and from any claims, demands, liability, or judgments arising out of my use of the Athletic Republic™ facilities and equipment.

_____/_____
Initial – If minor, parent/guardian/conservator also initial

PARENT/GUARDIAN/CONSERVATOR INDEMNIFICATION AGREEMENT

In consideration of my child/ward being permitted to use the Athletic Republic™ Program facilities and equipment I agree to indemnify and hold harmless this facility, its successors and assigns, and its officers, director, agents and employees of an from any claims, demands, liability, or judgments made by or on behalf of my child/ward arising out of or during my child/ward's use of the Athletic Republic™ Program facilities and equipment.

_____/_____
Initial

_____	_____	_____	_____
Signature	Date	Signature	Date
_____		_____	
Print Name		Print Name	
_____		_____	
Address		Address	

Asthma Policy

Purpose: To permit all athletes with a history of asthma, who are medically cleared by a physician, a conditional clearance for sports participation.

It is the policy of the Saint Francis Athletic Program to allow the athlete the optimal environment in which to train. This includes ensuring safe training practices and supervision, especially with pre-existing medical conditions. There are over 19 million asthmatics in the United States and, of these, 55. million are children (CDC). There are 6,000 reported deaths related to asthma in the U.S. and these numbers are increasing.

Due to the intense nature of the Athletic Republic Program, when as asthmatic athlete is cleared by a physician to participate, this clearance will be considered conditional.

Conditional clearance involves the following:

1. The asthmatic athlete's inhaler is always present in the training facility.
2. The asthmatic athlete must be stable with the proper medications.
3. When an athlete has to resort to using this/her rescue medications 2 times in an exercise period or more than 3 times per week he/she is unstable. The athlete should be referred to their physician for evaluation and perhaps an adjustment in their medication protocol.
4. If the asthmatic athlete uses his/her inhaler 3 times in 1 day, training will stop until he/she is re-evaluated by their physician and cleared to participate again.

Signed:

_____ _____

Athlete Date

_____ _____

Parent Date

Asthma Questionnaire
Saint Francis Athletic Republic Program

Please answer the following questions completely and accurately. Your answers to these questions will not disqualify you from participation in the Athletic Republic Program.

	YES	NO
Do you have asthma now?		
If you use an inhaler, please answer the following 3 questions honestly and accurately.		
1. Do you take your quick-relief inhaler more than 2x per week?		
2. Do you awaken at night with asthma more than 2x per week?		
3. Do you refill your quick-relief inhaler more than 2x per year?		
In the past 12 months:		
1. Have you had a sudden, severe episode or recurrent episodes of coughing, wheezing (high-pitched whistling sounds when breathing out), or shortness of breath?		
2. Have you had coughing, wheezing, or shortness of breath during or immediately after exercise?		
3. Have you had colds that "go to the chest" or take more than 10 days to get over?		
4. have you had coughing, wheezing, or shortness of breath during a particular season or time of the year?		
5. Have you had coughing, wheezing, or shortness of breath in certain places or when exposed to certain things (i.e. animals, tobacco smoke, perfumes)?		
6. Have you used any medications that helped you breath better?		
7. Are your symptoms relieved when the medications are used?		
In the past 4 weeks, have you had coughing, wheezing, or shortness of breath..?		
1. At night that has awakened you?		
2. In the early morning?		
3. After running, moderate exercise or other physical activity?		

Signed:

_____ _____

Athlete Date

_____ _____

Parent Date

SAINT FRANCIS MEDICAL CENTER

Medicine to the Highest Power

Photo/Media Consent Form

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below in this Photo/Media Consent Form, I understand that this authorization is voluntary. No individual has coerced me into signing this authorization, and I am providing this authorization under my own free will. I understand that once this information is received by the authorized organization or persons, then it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

I hereby authorize Saint Francis Medical Center and/or the requesting entities to:

Yes	No	
✓		Take video or still photos of me (or my child if he or she is a minor)
	✓	Interview me (including the use of an audio or video recording device)
	✓	Discuss my medical condition with a physician or other healthcare worker familiar with my case
	✓	Release a one-word condition report to requesting media outlets

Purpose of request:

Yes	No	
✓		For a print or electronic (television, radio or Internet) news or feature story
✓		For inclusion on a Saint Francis Medical Center entity Web site
✓		For a Saint Francis Medical Center print, television, outdoor or radio campaign
✓		For medical education

By signing below I acknowledge and affirm the statements in the Photo/Media Consent Form.

_____ _____

Signature of Individual or Individuals' Representative Date

_____ _____

Printed name of Individual or Individuals' Representative Date

_____ _____

Representative's Relationship to Individual Date

Yes	No	
☐	☐	I would like to receive copies of the pictures of a DVD of the final TV sports.

_____

Address

_____

City St Zip

PERMISSION TO PROVIDE MEDICAL TREATMENT AGREEMENT

I HEREBY give my permission for my son/daughter, _____ to undergo medical treatment for any injury or illness he/she may sustain or acquire while engaged in the Athletic Republic™ Program. I understand that the personnel of the Athletic Republic™ Program use only those procedures, which are within their training, credentialing and scope of professional practice to prevent, care for and rehabilitate injuries. In the event that more serious medical procedures are required, such as surgery or other invasive procedures, I understand that attempts will be made to contact me for my consent. I understand that if my child suffers a potentially life threatening injury or illness, and in the event I am unable to be contacted within a reasonable period of time, that I authorize any duly licensed medical practitioner to perform such procedures as may be medically necessary to alleviate the problem.

I have had the opportunity to ask questions regarding the release and all of my questions have been answered to my satisfaction. Having understood the above agreement, I freely sign the Permission to Provide Medical Treatment Agreement.

I acknowledge that the participant is under the age of 19. I have reviewed the information provided and certify it to be true and correct.

I consent to _____ participating in the evaluation and program.

_____ _____

Signature of Parent/Guardian/Conservator Date

POLICY FORM

Training Fees

Training fee advance deposits are necessary before scheduling any pretest and evaluations. These are non-refundable.

Athletic Republic™ Programs are non-transferable and are designed to be completed in 6-8 weeks in order to achieve optimal results. The fee balance will be held for 80 days from the start of the first workout. If after this time, training has not been completed, the remainder of your account will be forfeited.

Refunds

Training fees paid in full prior to any pre-test and evaluation will be subject to a cancellation fee of $75.00.

No refunds will be given once an athlete starts an Athletic Republic™ Program. If an athlete is unable to complete the training, due to an injury that occurred outside the Athletic Republic™ Program or other relevant circumstances that will not permit the athlete to finish, the remaining credit minus the cancellation fee of $75 will be kept on account for no longer than one year from the start of the first workout. If after this time the athlete has not used his/her credit the remaining amount will then be forfeited.

If at any time an individual is unable to complete a performance training program due to an injury sustained during actual Athletic Republic™ Program component training the prorated balance of their training fee may be refunded or maintained on account until the individual is able to complete their training.

Cash refunds will not be given. Individuals granted refunds will receive a credit for the amount paid, which may be used towards the purchase of other Athletic Republic™ Program services.

Scheduled Appointments

Any individual failing to show for a scheduled Athletic Republic™ Program session appointment will forfeit a paid session.

Cancellations are to be made one day in advance. Athletes canceling on the day of their appointment will be charged for that session. Early cancellations will lesson the possibility that you will have to forfeit a paid session.

Any athlete that is 5 to 15 minutes late for a scheduled appointment will receive a modified training session to fit the remaining time of the session. If the individual is over 15 minutes late for an appointment, they will forfeit that session.

I understand this Policy Form and its conditions.

If Client is a Minor

Client Signature	Date	Parent/Guardian/Conservator Signature	Date
Print Name		Print Name	
Address		Address	