HAYSMED
THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Testing Combine Registration

****** Please Print ******

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

School: _____ Current Grade: _____ Graduation Year: _____

Sports Played:

1) _____ Positions: _____
2) _____ Positions: _____
3) _____ Positions: _____
4) _____ Positions: _____

Would you like your results released to colleges for recruiting: **YES NO** If yes, which sport: _____

Emergency Contact Information:

Name: _____ Relationship to participant: _____

Telephone Number: _____ Alternate Telephone Number: _____

Are there any physical or medical conditions that could be aggravated by participation in this event? (Examples: Asthma, Seizures, Past surgeries, etc) If yes, please explain: _____
_____
_____

Release (Read carefully before signing this form):

I understand that engaging in any form of physical activity involves a risk of personal injury. I am in good physical condition and I have disclosed any and all conditions known to me that may impact my ability to participate in this event. I assume the risk of any injury that may result from my participation in activities in the Athletic Testing Combine presented by High Plains Sports Medicine and the Center for Health Improvement. In consideration for being permitted to participate in such an event, I hereby release, waive, and forever discharge Hays Medical Center and the testing facility (including its agents, employees, and officers) from any claim arising from my participation in this event. Further, I release said parties from any claim arising from any medical treatment rendered to me in connection with my participation in this event. I hereby authorize the staff of the Athletic Testing Combine to act on my behalf during this event in any emergency that may require medical attention.

I understand members of the media may be present during this event and the results of this event will be released to the media. I consent to the use of my name or a video or photographic image of me by Hays Medical Center or the media reporting on this event. I hereby authorize Hays Medical Center, Inc. to use, disclose, and/or publish video or photographic images of the person identified above. I understand that I can revoke this authorization at any time by contacting the Privacy officer at Hays Medical Center, Inc.

I understand college and university representatives may be present during this event and the results of this event will be released to such representatives. I understand the results also will be posted on the Hays Medical Center website. I consent to such releases of information relating to me.

Participant Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____
(If participant is under age 18)