NEW ATHLETE MEDICAL FORM

Plymouth State University

Student- Athlete Name: ____________________ Sport: ________________
Freshman □ Transfer/Yr of Graduation ________

- This form must be completed in its entirety prior to the first practice or you will not be allowed to participate.
- The information contained in this form is protected under medical confidentiality guidelines and will be used as an aid to providing appropriate health care while you are a student-athlete at Plymouth State University.
- Your knowledge and consent are required for release of any information contained in this medical record.

Completed forms must be returned to: Mark Legacy, Head Athletic Trainer
Department of Athletics [your sport] - or - FAX: 603-535-3090
Plymouth State University
17 High St., MSC 32
Plymouth, NH 03264-1595
ATTN: Mark Legacy

PLEASE RETURN VIA MAIL OR FAX - DO NOT SEND DUPLICATES

Personal Contact Information

Date of Birth: _______ Marital Status: Single □ Married □ Divorced □ Children? Yes □ No □
Home Address: __________________________________________ Telephone: ________________
(street) (city) (state) (zip)

(optional) – Do you or your family have any religious beliefs that would affect or restrict the medical assistance we provide for you if you become injured or ill while participating in athletics at Plymouth State University? Yes □ No □
Please explain if possible: ___________________________________________________________________________

Father’s name: ___________ Telephone: □ same as above □ Other: __________________________
Address: □ same as above □ Other: ____________________________________________________________

Mother’s name: ___________ Telephone: □ same as above □ Other: __________________________
Address: □ same as above □ Other: ____________________________________________________________

Family Health History

Please indicate if anyone in your family has a history of any of the following.

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Anemia</th>
<th>Arthritis</th>
<th>Asthma</th>
<th>Cancer</th>
<th>High Cholesterol</th>
<th>Depression</th>
<th>Diabetes</th>
<th>Epilepsy</th>
<th>Convulsions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
</tbody>
</table>

Relationship: ________________

Anything not listed above? No □ Yes □, please explain: __________________________________________________________________________

Please explain any positive answers from above: __________________________________________________________________________
**Personal Health History**

**Have you ever had or do you currently have:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest Pain w/ exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convulsions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Bridges/plates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness w/ exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear trouble/hearing loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fainting/Blackouts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches (frequent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches (migraine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart murmur</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis/Jaundice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mononucleosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart palpitations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinus infection(frequent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tendency to bleed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tendency to bruise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tumor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcer/ Stomach or other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicose Veins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Difficulties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others not listed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please explain any positive answers given above: __________________________________________________________

**Do you wear contact lenses?**

Yes  No

**Surgical History:**

Please list, giving dates and explanations, any surgeries you have had:

__________________________________________________________________________________________________

**Hospitalization History:**

Please list, giving dates and explanations, any hospitalizations:

__________________________________________________________________________________________________

**Current Medications:**

Are you currently taking any medications?  Yes  No

*Please provide names and dosages for any medications you are taking:*

___________________________________________________________________________________________________

**Allergies: Please indicate if you have any of the following allergies**

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ice (Cold)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bees / Wasps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs / Medications</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, do you have/use a bee sting kit?  Yes  No

Please explain: ________________________________________________________________

Please explain: ________________________________________________________________

**************  **Women Only: Please indicate if you have any of the following  **************

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irregular periods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe Cramps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast lumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive menstrual flow</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What was your age at menstrual onset? __________________

In the past year, what was the longest time b/w your periods? __________________

Do you know, or is there any possibility that you may be pregnant?  Yes  No

*************************************************************************************************
Do you currently have, or have you ever had, any of the following injuries that caused you to miss at least 1 game or practice, or required X-rays or other diagnostic imaging? *This information will help us better care for your injuries (present and future). Please be honest and complete to the best of your ability.*

A. **Concussion(s) &/or Skull Fracture**
   - Yes □  No □  When?
   - Explain: ___________________________

B. **Neck Injuries, including burners/stingers**
   - Yes □  No □  When?
   - Explain: ___________________________

C. **Shoulder injuries**
   - Yes □  No □  When?
   - Explain: ___________________________

D. **Elbow Injuries**
   - Yes □  No □  When?
   - Explain: ___________________________

E. **Wrist / Hand Injuries**
   - Yes □  No □  When?
   - Explain: ___________________________

F. **Rib / Chest Injuries**
   - Yes □  No □  When?
   - Explain: ___________________________

G. **Back / Spine**
   - Yes □  No □  When?
   - Explain: ___________________________

H. **Hip / Thigh Injuries**
   - Yes □  No □  When?
   - Explain: ___________________________

I. **Knee Injuries**
   - Yes □  No □  When?
   - Explain: ___________________________

J. **Lower Leg Injuries**
   - Yes □  No □  When?
   - Explain: ___________________________

K. **Ankle / Foot Injuries**
   - Yes □  No □  When?
   - Explain: ___________________________

Do you currently wear any special equipment / padding / braces or other devices to participate in athletics?
Yes □  No □  Please explain: ___________________________

********************************************
******* By signing this form I understand and agree to the following: *******
1. If I am removed from a practice or game, or willingly leave a practice or game due to an injury or illness, I must have appropriate medical clearance before I can return to participation.
2. I grant permission to PSU athletic trainers, personnel, or agents to secure necessary and appropriate emergency and nonemergency medical care in the event that I am injured or ill.
3. I understand that having a physical examination does not necessarily mean that I am physically qualified to engage in athletics but only that the evaluator did not find a medical reason to disqualify me at the time of examination.
4. All of the information contained in this form is correct and true to the best of my knowledge.

Student-Athlete Name: ___________________________________________  Sport: __________________________

Student-Athlete Signature: ______________________________________ Date: _________________________
Plymouth State University

Physical Examination Form

Sport(s): ________________

This form must be completed and signed by a licensed Health Care Professional authorized to conduct a physical examination in order to be considered valid.

Student-Athlete Name: ________________________________________    Date of Birth: ____ / ____ / _______

Gender:      M       F

Date of Last Tetanus Booster: ___ / ___ / _______    Height: _____    Weight: _________

Pulse: ______ bpm    Blood Pressure: _____ /______ mmHg    Visual Acuity: L _____ R_______

Corrective Lenses?    Yes    No    Type:  Glasses  Contacts  Both

Are there any abnormalities of the following systems?

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>If “yes” please explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, Ears, Nose, Throat, or Mouth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck / Thyroid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory / Lungs</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cardiovascular / Heart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auscultations (supine &amp; standing)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical stigmata of Marfan’s syndrome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hernia</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Urogenital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin / Integumentary</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Status</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Musculoskeletal Examination: Any abnormalities (decrease ROM or strength, laxity) or current injury to:

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>If “yes” please explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbows / Forearms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hands / Wrists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spine / Back</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hips / Thighs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ankles / Lower legs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feet</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is there loss or seriously impaired function of any paired organ? Yes ___ No ___

Explain

Recommendation for Participation in Intercollegiate Athletics: Unlimited ___  Limited ___  Prohibited ___

If limited, is there any further information which would be helpful in meeting the health care needs of this student-athlete, or any special equipment / padding / brace / device required for participation?

I hereby certify that the above information is completed to the best of my knowledge.

Health Care Provider Name: _______________________________ Phone (    )     _ _  Fax  (    )      .

Address ___________________________________________________________________________________________

(please print or stamp)

Health Care Provider Signature: __________________________________        Date: __________________________
Emergency Contact Information

Student-Athlete Name: _______________________________  Sport: __________________

Date of Birth: _______  Age: ______ years  Academic Year: [ ] Freshman  [ ] Soph  [ ] Junior  [ ] Senior

Local (PSU) Address: HUB Suite #: ________________________________
Local (PSU) phone: _______________  Mobile Phone: ____________________

Parent / Spouse Name(s): ________________________________
Parent Address: ____________________________________________

Parent Primary Phone: _______________  Alternate Phone: _______________

Secondary Emergency Contact Name: ________________________
Relationship: _____________  Contact Phone: _______________________

Insurance Policy Information

Policy Holder’s Name: _______________________________  Relationship to Student-Athlete: _____________
Policy Holder’s Address: ________________________________  Home Phone: _______________

Insurance Company: ________________________________  Identification Number: _______________
Group / Plan Number: ________________________________  Work /Mobile Phone: _______________
Insurance Phone: ________________________________  Insurance Company Address: ________________________________

Effective Date of Policy: _______________  Expiration date of Policy: _______________

Does this insurance policy cover athletic related injuries?  [ ] yes  [ ] no
Please check one:  [ ] HMO  [ ] PPO  [ ] other

DOES THIS POLICY REQUIRE A REFERRAL FROM THE PRIMARY CARE PHYSICIAN (PCP) TO SEE A SPECIALIST?
[ ] yes  [ ] no

Primary care physician (PCP): ________________________________
PCP phone: _______________
PCP Fax: _______________
PCP office address: ____________________________________________

By signing this form I am declaring that all information provided is complete and correct to the best of my knowledge.

Student-Athlete Signature: _______________________________  Date: _____________________

Parent / Guardian Signature (if student is under 18 yrs): ________________________________
Acknowledgement of Insurance Requirements

PLEASE REVIEW THIS SECTION WITH THE GUARANTOR OF YOUR INSURANCE POLICY

For Parents
I, ____________________________, as parent / guardian or legal representative, attest that my son/daughter, ________________________________, has insurance coverage under a current, in force insurance policy for injuries that occur while he / she is participating in intercollegiate athletics.

For Student-Athlete (if he/she has a personal insurance policy not under a parent / guardian policy)
I, ________________________________, attest that I have insurance coverage under a current, in force insurance policy for injuries that occur during my participation in intercollegiate athletics.

I agree to notify Plymouth State University Athletic Training Services immediately if there is a material change in my insurance coverage or if there is an expiration of the coverage information that I have submitted.

I understand and agree that Plymouth State University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting from injuries that occur while participating in intercollegiate athletics.

Student-Athlete signature: _______________________________ Date: ______________

Parent / Guardian signature (if student is <18 yrs): _____________________________ Date: ______________

A COPY (FRONT & BACK) OF CURRENT INSURANCE CARD MUST BE INCLUDED WITH THIS FORM
Assumption of Risk for Intercollegiate Athletic Participation

By its nature, participation in intercollegiate athletics includes the risk of injury which may range in severity from minor to long term catastrophic, including but not limited to, permanent paralysis from the neck down and/or death. Although serious injuries are not common in supervised intercollegiate athletic activities, it is possible only to minimize, not eliminate risk. Participants can and have the responsibility to help reduce the chance of injury. Student-athletes must obey all safety rules, report all athletic injuries to the certified athletic trainers, follow a proper conditioning program and inspect all protective equipment daily. By signing this form, I acknowledge that I have read and understand this warning.

Student-Athlete Signature: ________________________________________________  Date: _____________
Parent/Guardian Signature (if athlete is < 18 yr): _______________________________  Date: _____________

Consent for Medical Treatment

I hereby grant permission to the Plymouth State University Athletic Training Staff and team physicians to provide me with medical care in the event that I become injured while participating in intercollegiate athletics. I understand that any treatment, medical or surgical care that is provided to me will be given only when considered medically necessary for my health and well being. By signing this form, I acknowledge that I have read and understand this consent.

Student-Athlete Signature: ________________________________________________  Date: _____________
Parent/Guardian Signature (if athlete is < 18 yr): _______________________________  Date: _____________

Authorization to Release Information

I hereby authorize and request that the Plymouth State University athletic trainers and/or their consulting physician(s) furnish any and all requested information directly pertaining to my participation in athletics at Plymouth State University to physicians, professional team representatives, their agents, scouts or athletic trainers. Said authorization shall include, but is not limited to: information concerning my physical condition, illnesses, injuries, treatments, hospitalizations, examinations, and diagnostic testing and imaging. By signing this form I am fully discharging all parties to whom this authorization extends from any and all penalties of breach of student-athlete confidentiality under the Family and Educational Right to Privacy Act and the Health Insurance Portability and Accountability Act.

Student-Athlete Signature: ________________________________________________  Date: _____________
Parent/Guardian Signature (if athlete is < 18 yr): _______________________________  Date: _____________

Medical Referral and Primary Care Authorization

Any appointment made with medical specialists (orthopedist, podorthist, neurologist, etc...) may require a referral from the primary care physician. It is the student-athlete’s responsibility to acquire this referral prior to any appointment or office visit. **Plymouth State University is not responsible for any medical expenses incurred while participating in intercollegiate athletics.** Participation in athletics at Plymouth State University is limited to student-athletes who are covered by a primary medical health insurance policy. Plymouth State University does not offer medical insurance coverage to student-athletes. By signing this form, I hereby accept responsibility for obtaining all necessary referrals and understand that I am responsible for any and all charges incurred during medical treatment.

Student-Athlete Signature: ________________________________________________  Date: _____________
Parent/Guardian Signature (if athlete is < 18 yr): _______________________________  Date: _____________
CONSENT TO PARTICIPATE IN DRUG TESTING

&

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby acknowledge the receipt of a copy of Plymouth State University’s Athletic Department Drug Education, Testing and Treatment Policy. This policy has been explained to me and I have been given the opportunity to ask any questions. I further acknowledge that I have read this policy and fully understand and agree to comply with this policy in full.

I understand that signing this consent form and returning it is a prerequisite to my becoming a member of any intercollegiate athletic team at Plymouth State University. I understand that I may refuse to sign this consent form but, as a consequence, I will forgo participation in athletics at Plymouth State University. I am aware that I am expected to abide by team rules, that those rules are subject to change based on the discretion of the coach and that I may be dismissed from the team for failure to abide by such rules. I am also aware that I may be subject to further disciplinary action under general student body rules applicable to all students at Plymouth State University, outside any athletic sanctions.

I acknowledge my understanding that the use of drugs not prescribed by a physician for a specific medical condition, or abuse of prescription medications, is a violation of team rules, athletic department and university policy and is unlawful. I hereby consent to have samples of my urine (and/or saliva) collected and tested for the presence of certain drugs or substances in accordance with the provisions of the Plymouth State University Drug Education, Testing and Treatment Policy.

I authorize the Director of Athletics and/or the Drug Education Testing and Treatment Coordinator at Plymouth State University to make confidential use of the results of any drug test to the Head Coach of all sports in which I am a participant, physicians, a Counseling Center representative and my parent(s) or legal guardian(s). The released information may include: all information and records related to screening or testing of my urine (or saliva) sample(s) in accordance with the PSU policy. To the extent set forth in this document, I waive any privilege I may have in connection with such information. I agree that in the event the results of my drug test are positive, I will follow the procedures required following a positive test result.

I hereby fully and forever release and discharge Plymouth State University, its Board of Trustees, officers, employees and agents from any claims, demands, damages, rights of action or causes of action present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from my participation in the Drug Education, Testing and Treatment Program. I understand that I may be tested at any point during my tenure as a Plymouth State University athlete.

Signature: ___________________________ Date: ____________

Parent / Guardian Signature: ___________________________ Date: ____________

(Required if Student-Athlete is < 18 years of age)
SICKLE CELL TRAIT TESTING CONSENT/REFUSAL AND RELEASE

Sickle Cell Trait is a genetically inherited condition that affects red blood cells during intense exercise. NCAA student-athletes with sickle cell trait have experienced significant physical distress during extreme conditioning and some have even died. **Those student-athletes who have Sickle Cell Trait and who participate in football, basketball, track and field, wrestling and/or soccer are at higher risk of complications during training.** Certain student-athletes are at higher risk of having this condition, specifically students who are of African-American and Hispanic descent.

The Plymouth State University (PSU) Department of Intercollegiate Athletics (ICA) has provided me with educational materials regarding Sickle Cell Trait and the risks associated with it. I understand that the NCAA and PSU require **ALL** incoming Division III student-athletes be tested for Sickle Cell Trait, performed by the student-athletes Primary Care Physician (PCP), at the expense of the student-athlete, provide documented results of a prior test to ICA or decline the test and sign a waiver releasing PSU from liability.

I acknowledge and understand that if I test positive for Sickle Cell Trait, I will **NOT** be restricted from playing in my sport. However, for my health and safety, certain precautions will be taken with respect to my training and I will be removed from training if I develop symptoms associated with Sickle Cell Trait. I acknowledge that I have had a full opportunity to ask questions I have about the diagnosis of Sickle Cell Trait and to discuss the risks associated with participation in intercollegiate athletics at PSU if I have Sickle Cell Trait. Any questions or concerns I had, if any, have been addressed to my satisfaction. I understand the risks involved if I choose NOT to be tested for Sickle Cell Trait, and knowingly assume such risks.

Please initial one line below.

*NOTE - If you choose options 1 or 2, you CANNOT be cleared for participation until you provide PSU Athletic Training with the results of your Sickle Cell Trait Test.*

_____ I have received this information and **AGREE** to be tested for Sickle Cell Trait, **assuming all expenses associated with such testing.**

_____ I HAVE SHOWN PSU the results of a prior Sickle Cell Trait test

*NOTE - If you choose option 3, you must view the Sickle Cell Informational Video at: http://s3.amazonaws.com/ncaa/web_video/health_and_safety/sickle_cell/sickleCell.html*  

_____ I have received this information and I **DECLINE** a blood test for Sickle Cell Trait. I understand that by refusing to undergo screening for Sickle Cell Trait, I assume all risks associated with such refusal and, in consideration for being granted the opportunity to participate in intercollegiate athletics at PSU without agreeing to be tested for Sickle Cell Trait, I (for myself, my executors, administrators and assigns) hereby release and forever discharge Plymouth State University and the State of New
Hampshire and their regents, officers, employees, agents, representatives, coaches, physicians, instructors and volunteers from any and all liability, actions, causes of action, debts, claims or demands of any kind and nature directly or indirectly related to any personal injury, including death, bodily injury, mental anguish or emotional distress that I may suffer related in any way to my participation in intercollegiate athletics, whether caused by my negligence or carelessness. These risks have been discussed with me and I have made this decision on a fully informed basis. I understand that this release means that, among other things, I am giving up my right to sue Plymouth State University for any such loses, damages, injury or costs that I may incur. I represent and certify that I am at least 18 years old and that I have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be legally bound by this document.

____________________  __________________________
NAME (please print)             Signature

____________________
DATE

____________________  __________________________
PARENT/GUARDIAN SIGNATURE   DATE
( Required if under 18 years old)