Club Sports Forms Packet

Liability Release Form
General Information Form
Insurance Information Form
Physical Evaluation Form
Liability Release For Participating Student Athletes

In consideration of the use of Harmony School of Advancement gymnasium, and participation in sport related activities under jurisdiction of North American University, the undersigned agrees to the following:

1. **Risk factors:** I acknowledge and understand that the use of facilities, equipment, and services provided by North American University and Harmony School for physical sports, may involve risks. Such as the following: **Risk of property damage, bodily injury and possible death.** All of which might result from the use of facilities or equipment, from the activity itself, from the acts of others or from the unavailability of emergency or emergency medical care.

2. **Assumption of risk:** I undertake all risks that may arise out of the use of the equipment or facilities, the activity itself, the act of others or the unavailability of emergency care, including but not limited to those risk factors described.

3. **Acknowledgement of policies and procedures:** I acknowledge reading and knowing all of the policies and procedures relating to the North American University Emergency Response guide and will follow directions accordingly if an emergency is to arise.

4. **Prerequisite skills and training:** I acknowledge that I will receive training and prerequisite skills that are involved in the physical activity that I am participating in. When my coach, director, or teacher has given me the proper training is when I am allowed to partake fully in the physical activity. Until then I will not defy and will undergo the training my coach, director, or teacher lets me partake in.

5. **Release:** I release the State of Texas, the North American University Advisory Board, North American University, Harmony Schools, Harmony Schools and North American University organizations, the officers, employees and agents of each and agree NOT TO SUE them on account of or in conjunction with any claims, causes of action, injuries, damage, cost of expenses arising, out of the activity, including those based on death, bodily injury or property damage whether or not caused by the acts, omissions or other fault of the parties being released.

6. **Waiver:** I waive the protection afforded by any statute or law in any jurisdiction. This means, in part, that I am releasing unknown future claims.

7. **Indemnify and defend:** I agree to insure and defend the State of Texas, the North American University Advisory Board, North American University, Harmony Schools, Houston, Harmony Schools and North American University’s organizations, the officers, employees and agents of each against and hold them harmless from any or all claims, causes of action, damage judgments, costs or expenses, including attorney fees which in any way arises from the activity or this agreement which include but not limited to the following stated above and below.
8. **Pay**: I agree to pay for any or all damages to any property or insurances caused by I (myself) either negligently, willfully or otherwise.

9. **Representatives**: I enter into this agreement for myself, my heirs, assigns and legal representatives.

10. **Emergency treatment consent**: I, as a participant in the physical activity, hereby consents to such treatment.

11. **Insurance**: I understand that the college and its auxiliaries do not carry participant insurance. I am encouraged to have a physical examination and to purchase health insurance prior to any and all participation.

12. **Acknowledgement**: I have read and understand this agreement and realize it relates to surrendering valuable legal rights and does so freely.

_______________________________
(Print)

_______________________________
(Signature)

Emergency Contact Information:

Name:______________________________________________________

Phone number: ______________________________________________

Email Address: ________________________________________

Relation: ______________________________________________
Student Athlete General Information

Athlete’s Name: __________________________________________
Sport: __________________ Age: _______ Date of Birth: ____________
Social Security Number: _________________________________
Athlete’s Direct Phone #: _________________________________
Athlete’s Second Phone #: _________________________________
College Address: _________________________________________
Current Address: __________________________________________
City: __________________ Zip Code: __________ State: __________
Email Address: ___________________________________________

Emergency Contact Name: ________________________________
Phone #: __________________ Relation: ______________________
Father/ Guardian Name: __________________________________
Phone #: ______________________________________________
Email Address: __________________________________________
Address: _______________________________________________
City: __________________ Zip Code: __________ State: __________
Father’s Employer: ________________________________________
Employer’s #: __________________________________________
Employer’s Address: ______________________________________
City: __________________ Zip Code: __________ State: __________

Mother/ Guardian Name: __________________________________
Phone #: ______________________________________________
Email Address: __________________________________________
Address: _______________________________________________
City: __________________ Zip Code: __________ State: __________
Mother’s Employer: ________________________________________
Employer’s #: __________________________________________
Employer’s Address: ______________________________________
City: __________________ Zip Code: __________ State: __________

Student Athlete (Print) ___________________________ Date _____________

Student Athlete (Signature or if under the age of 18, Guardian Signs) Date _____________
Student Athlete Insurance Information

Please include copies of insurance and prescription cards.

Student Athlete Name: ___________________________________________________________
Sport: ___________________ Birthdate: ___________________ Gender: ______________
Social Security #:_________________________ Home Phone #: _________________________
Cell Phone #: _________________________ Work Phone #: _________________________
Home Address: _________________________________________________________________
City: __________________ State: ____________ Zip Code: ______________________
Current Address: _________________________________________________________________
City: __________________ State: ____________ Zip Code: ______________________
Employer Name: _________________________________________________________________
Employer’s #: __________________
Employer’s Address: _________________________________________________________________
City: __________________ State: ____________ Zip Code: ______________________
Insurance Company: ____________________________________________________________
Insurance Phone #: _____________________________________________________________
Group Policy #: _________________________ Certificate #: ____________________________
Insurance Address: _________________________________________________________________
City: __________________ State: ____________ Zip Code: ______________________
Are you covered under your employer’s insurance?  Circle:  Yes  No

Father/ Guardian Name: ________________________ Social Security #:_________________
Home address: _________________________________________________________________
City: __________________ State: ____________ Zip Code: ______________________
Home #: _______________ Work #: _______________ Cell #: _______________
Father’s Employer Name: ____________________________________________________________
Employer’s #: __________________
Employer’s Address: _________________________________________________________________
City: __________________ State: ____________ Zip Code: ______________________
Insurance Company: ____________________________________________________________
Insurance Phone #: _____________________________________________________________
Group Policy #: _________________________ Certificate #: ____________________________
Insurance Address: _________________________________________________________________
City: __________________ State: ____________ Zip Code: ______________________
Is your daughter/son covered by the above policy?  Circle:  Yes  No
Mother/ Guardian Name: ___________________________ Social Security #:_________________
Home address: ________________________________________________
City: ___________________ State: ___________________ Zip Code: __________________
Home #: __________________ Work #:__________________ Cell #: __________________
Mother’s Employer Name: __________________________________________
Employer’s #: ________________________________________________
Employer’s Address: __________________________________________
City: ___________________ State: ___________________ Zip Code: __________________
Insurance Company: ____________________________________________
Insurance Phone #: ____________________________________________
Group Policy #: ____________________ Certificate #: __________________
Insurance Address: ____________________________________________
City: ___________________ State: ___________________ Zip Code: __________________
Is your daughter/son covered by the above policy?   Circle:   Yes    No
Pre-Participation Physical Evaluation Participating Sports Athletes

Student’s Name: _________________________ Age: _____ Gender: ___________ D.O.B.: __________
Height: ___________ Weight: _______ Percent of body fat (optional): ________________________
Pulse: ____________ Blood Pressure: ______________
Vision: R 20/_______ L 20/ _______ Corrected: Yes ☐ No ☐ Pupils: Equal ☐ Unequal ☐

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<td>Genitalia (males only)</td>
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<td>Foot</td>
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Cleared ☐ Cleared after completing evaluation/rehabilitation ☐ Not Cleared ☐

Notes: ☐ ☐ ☐

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

The following information must be completed and signed by either a physician’s assistant licensed by a State Board of Physician Assistant Examiners, or a registered nurse recognized as an advanced Practice Nurse by the Board of Nurse Examiners. Examination forms signed by any other healthcare practitioner will not be accepted.

Physician Name: _________________________________ Date of Examination: ________________
Full Address: ___________________________________________
Phone #:__________________ Physicians Signature: _________________________________