New Athlete Information

Athlete's Name _____

Birthday ___/___/_____ Sex - M F Age _____ Height _____ Weight _____

School/Occupation _____

Sport 1 _____ Sport 2 _____

Coach _____ Coach _____

How did you hear about us? _____

(i.e., Friend, Coach, Flyer, Employee referral)

Contact Name _____ Emergency Contact _____

Billing Address _____ Emergency Phone _____

City, State, Zip _____ Alternate Phone _____

Home Phone _____ Email Address _____

I, or as Parent or legal guardian, hereby guarantee this information to be correct and guarantee payments in full for the charges incurred for the training of my child or myself.

Parent/Guardian Signature _____ Date _____

_____ _____

PHOTO/VIDEO RELEASE FORM

I hereby give permission for images of my child, captured during training through video, and digital camera, to be used solely for the purposes of Tekulve Acceleration Sports Training's promotional material, and publications including Social Media sites and website, and waive any rights of compensation or ownership thereto.

Name of Participant (please print): _____ Age:_____

Name of Parent/Guardian (please print): _____

Parent/Guardian's Signature:_____ Date_____

Medical History and Informed Consent

1. Do you have a history of any of the follow? Asthma _____ Anemia _____ Heart Murmur _____
   Convulsions _____ Diabetes _____ High Blood Pressure _____ Epilepsy _____
2. Have you ever experienced a heat injury? Yes _____ No _____
3. Do you take any over-the-counter medications on a regular basis? Yes _____ No _____
   Please List: _____
4. Are you presently taking any prescription medications? Yes _____ No _____
   Please List: _____
5. Do you have any allergies? Yes _____ No _____
   Please List: _____
6. Have you ever sustained an injury to any of the following? Neck _____ Shoulder _____ Ankle _____
   Wrist _____ Elbow _____ Hip _____ Knee _____ Back _____
7. **Please list any surgeries and dates.**
   _____
8. Where you ever advised to wear a brace or harness during sports? Yes _____ No _____
   Please List: _____
9. Do you suffer from any of the following? Blisters _____ Shin Splints _____ Stress Fractures _____
10. Please list the date of your last physical exam.
11. Any other medical conditions or complications we should be made aware of? _____
    _____

Please read the following information regarding the fitness protocols. If you have any questions do not hesitate to ask.

1. My participation is voluntary, and I may withdraw from the evaluation at anytime.
2. Testing will be done by the staff of **Tekulve Acceleration Sports Training.**
3. I hereby consent to and permit **Tekulve Acceleration Sports Training** to use the data obtained in reports or publications, but my identity will not be associated with such reports.
4. I understand that this evaluation should not result in physical injury to me. However, I acknowledge the following: During the **Tekulve Acceleration Sports Training** program, as well as during any vigorous exercise, there exists the possibility of certain changes and risks during the workouts. These may include abnormal blood pressure, a feeling of being light headed, nausea, disorders of heartbeat and in rare instances heart attack or stroke. Every effort will be made to minimize these abnormalities by observation during the workouts.
5. I acknowledge that **Tekulve Acceleration Sports Training** is relying on all information provided by me regarding my medical history and condition before allowing me to participate in any evaluation or program. I certify that the information provided to be true and correct.

I have reviewed the medical history, payment/ cancellation/refund policies and the informed consent. The information is true and correct. I represent that we currently have medical insurance, and I consent to _____ participating in the **Tekulve Acceleration Sports Training** program. (Athlete's Name)

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Parent/Guardian _____ Date _____

Signature _____ _____

PAYMENT/REFUND/CANCELLATION POLICY

THE COST OF ONE LEVEL OF TRAINING IS $455.00

Payment in full is required at the time the program is initiated. No refunds will be given; a credit will be held for the remaining visits, this program is non-transferable and expires 90days from the time the first visit is completed. No extensions will be given on this program unless the athlete is injured. A physician's letter is required in order to extend the program.

CANCELLATION POLICIES

If a scheduled workout is missed and not cancelled prior to the appointment time it will result in the loss of that workout.

I, or as Parent or legal guardian, hereby guarantee this information to be correct and I have read and understood all payment/refund/cancellation information and guarantee payments in full for the charges incurred for the training of my child or myself.

Parent/Guardian Signature_____ Date: _____

Our School Hours:

Monday 2:45 - 8:00
Tuesday 2:45 - 8:00
Wednesday 2:45 - 8:00
Thursday 2:45 - 8:00
Friday 2:45 - 6:00
Saturday 9:45 - Noon Every Other Open

Please Call 513-474-4525 to
Schedule Your Appointments
Thank You

Clinic Copy

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