GymTyme Illinois

Athlete Application
2017-2018

Please complete this form and submit with your $50 registration/tryout fee.

Select your program: ☐ Tiny All Star Cheer ☐ Mini All Star Cheer ☐ Youth-Senior All Star Cheer
☐ All Star Dance ☐ PrepTyme Full Season ☐ PrepTyme Half Season ☐ Special Abilities Cheer

ATHLETE INFORMATION

First Name: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (_____)_____ Athlete Cell Phone *(optional)*: (_____)_____

Date of Birth ___/___/___ Age as of August 31, 2017 _____ Male Female

Medical Conditions/Allergies:_____

PARENT /GUARDIAN INFORMATION

Please provide at least one (1) responsible party who will serve as primary contact and one (1) emergency contact in case the primary cannot be reached.

Mother's Name:_____

Cell Phone: (_____)_____ Email: _____

Father's Name:_____

Cell Phone: (_____)_____ Email: _____

Legal Guardian:_____

Cell Phone: (_____)_____ Email: _____

Emergency Contact:_____

Relationship to athlete:_____Emergency Contact Phone: (_____)_____

Office use only: ☐ $50 Registration Fee _____

☐ GymTyme Waiver ☐ EAC Waiver ☐ Financial Contract

☐ Payment Authorization ☐ Member Agreement ☐ ICP Account

Tryout number

Participation Waiver
2017-2018

This form MUST be completed before participation in any GymTyme Illinois activity.

Participant Name:_____

Parent/Legal Guardian Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone: (_____)_____ Email:_____

Medical Conditions/Allergies:_____

Emergency Contact:_____

Relationship:_____Emergency Contact Phone: (_____)_____

Please initial each section and complete with your signature at the bottom of page 2.

_____ **Assumption of Risk** I the undersigned (if applicant/participant is 18 years of age or older) or parent/guardian of above listed minor applicant/participant acknowledge and fully understand that each applicant/participant will be engaging in activities that involve risk of serious injury, including permanent disability or death, and severe social and economic losses which might result not only from their own actions, inactions or negligence, but action, inaction or negligence of others, or the condition of the premises or of any equipment used and further, that there may be other unknown risks not reasonably foreseeable at this time, assume all the foregoing risk and accept personal responsibility for the damages following such injury, permanent disability or death. I hereby release, discharge, covenants to indemnify and not to sue GymTyme Illinois, its affiliated organizations and sponsors, their coaches, and associated personnel, officers, directors, board members, including the owners and leasers of premises used to conduct the event, all of which are hereinafter referred to as 'releasees', from any and all liability to each of the undersigned, his/her heirs or next of kin for any and all against any claim by or on behalf of the applicant as a result of the applicant's participation in the programs of cheerleading, classes, lessons or any program or activities of GymTyme Illinois and/or being transported to or from the same, which participation, after careful consideration I hereby authorize, and which transportation I hereby authorize.

_____ **Consent for Treatment** The applicant/participant has received a physical examination by a physician and has been found physically capable of participating in the sport of cheerleading, tumbling, and other gym activities. I hereby give my consent to have an athletic trainer, coach and/or doctor of medicine or dentistry or associated personnel to provide the applicant/participant with medical assistance and/or treatment and agree to be financially responsible for the cost of such assistance and/or treatment. I accept that all parties herein referred to above as releasees are not to be held responsible for any pre-existing medical conditions or any medical conditions I fail to disclose on my health history. I also agree to save and hold harmless and indemnify above releasees from all liability, loss, cost, claim or damage whatsoever, including death or damage to property, which may be imposed upon said releasee because of any defect in or lack of such capacity to so act or caused or alleged to be caused in whole or in part by the negligence of the releasee.

_____ **Photographic Release** I hereby authorize GymTyme Illinois and its designated photographers, hereafter referred to as "GTIL," to publish photographs taken of myself (if 18 years of age or older) or my minor child for use in GTIL's print, online and video-based marketing materials, as well as other GTIL publications. I hereby release and hold harmless GTIL from any reasonable expectation of privacy or confidentiality for myself or my minor child associated with the images specified above. Further, I attest that I have full authority to consent and authorize GymTyme Illinois to use such likenesses. I further acknowledge that participation is voluntary and that I waive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other GTIL publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever. I hereby release GymTyme Illinois, its contractors, its employees and any third parties involved in the creation or publication of GTI publications, from liability for any claims by me or any third party in connection with my participation or the participation of my minor child.

Participation Waiver 2017-2018

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and The Family Educational Rights and Privacy Act (FERPA) of 1974 require that we guard the privacy of your protected health information. You have the right to confidential treatment of all information and records pertaining to your care; as well as full consideration of privacy concerning your treatment and rehabilitation plan. You also have the right to be advised as to the reason for the presence of any individual during the course of your medical care. If you sustain an injury while participating at GymTyme Illinois, it is important to understand that we may need to discuss your injury with your coaches, parents, and/or other people involved in your care. We may need to discuss issues relevant to your care only under the following circumstances:

1. You have given oral or implied consent through your actions
2. You have initialed/signed this authorization form, which permits us to disclose health information.

It is important to know that we will only release the minimum amount of information necessary to protect you.

_____ **Authorization to Disclose Private Health Information** I grant permission to the certified athletic trainer(s)/chiropractor, hereinafter referred to as "the practice," to disclose my personal health information (written and/or verbal), when requested to do so, for the purposes of health care treatment, payment for treatment, or for any other purpose which is permitted or required for law. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereof. I acknowledge and agree that the practice's privacy notice has been provided to me prior to me signing this consent and that the Notice includes a complete description of the uses and/or disclosures of my Protected Health Information (PHI) necessary for the Practice to provide treatment to me and also, necessary for the practice to obtain payment for that treatment and to carry out health care operations. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent and has encouraged me to read the Privacy Notice carefully prior to my signing this consent. I further understand that the practice reserves the right to change its privacy practices that are described in its Privacy Notice in accordance with the applicable law. The practice's Privacy Notice is provided at the time of the patient's first visit and is always available with the staff at the reception desk. I may also request a copy from this office at any time via US Mail. This Notice of Privacy Practices also describes my rights and duties of this office with respect to my Protected Health Information (PHI) I have read and understand the forgoing notice and all of my questions have been answered to my complete satisfaction in a way that I can understand.

_____ **Authorization to Release Private Health Information** This authorizes the certified athletic trainer(s)/chiropractor, hereinafter referred to as "the practice," to release information concerning my medical status, medical condition, injuries, prognosis, diagnosis and related personally identifiable health information to the coaches, assistant coaches, and my parents/guardians when deemed appropriate. This information includes injuries or illnesses related to past, present or future participation in athletics at GymTyme Illinois. I understand that the entities that receive the information may not be health care providers or health plans covered by federal privacy regulations, and that the information described above may be disclosed publicly and the information will no longer be protected by those regulations. I understand that GymTyme Illinois will not receive any compensation for its use of the information. I understand that I may inspect or copy any information used under this authorization. I understand that I may revoke this authorization at any time by notifying the practice in writing.

_____ I have read the above waiver/release and understand that (I) we have given up substantial rights by signing this release and sign below voluntarily.

_____ I the undersigned (if applicant/participant is 18 years of age or older) or parent/guardian of listed minor applicant/participant, acknowledge and agree that I am the parent or legal guardian of the above named minor and therefore have the authority to grant these permissions.

_____ This authorization expires one year from the date it is signed.

_____ _____

Athlete Signature (if 18 years of age or older) Date:

_____ _____

Parent/Guardian Signature: Date:

The Elite Athlete Informed Consent 2017-2018

All GTIL athletes must complete this form to recieve athletic training /chiropractic services while enrolled.

Please read and initial each of the terms listed below followed by your signature and the date.

_____ I hereby request and consent to the performance of chiropractic care and other procedures within the scope of the practice of chiropractic on me (or the patient named below, whom I am legally responsible) by Dr. Melissa Ryan, Dr. John Silosky and/or other licensed chiropractors and their staff who now or in the future treat me while employed by, working or associated with or serving as a back-up for Dr. Melissa Ryan and/or Dr. John Silosky.

_____ I understand the purpose of this visit and any subsequent visit is to acquire chiropractic care. A natural and conservative approach to my health needs, chiropractic care utilizes, but is not limited to, manipulation or joint adjustments, muscle testing, manual therapy, acupressure/acupuncture, electrical stimulation, ultrasound therapy, heat therapy, ice therapy, taping, nutrition, and various modes of physiotherapy. I understand that a definitive diagnosis may require further testing (e.g. x-rays, laboratory test, MRI, etc.) and/or referrals to other health care professionals.

_____ Although Dr. Ryan and Dr. Silosky may prescribe or suggest these tests and/or referrals, it is my responsibility to schedule an appointment and to acquire these tests and/or referrals.

_____ I have had an opportunity to discuss with Dr. Ryan, Dr. Silosky and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that Dr. Ryan and Dr. Silosky are not promising a cure for any symptom, disease, or condition as a result of treatment. I understand that results are not guaranteed.

_____ I understand that this practice may use trained staff personnel to assist the doctor with portions of the consultation, examination, electrical stimulation, ultrasound therapy, cupping, manual therapy, exercise instruction, or other services.

_____ I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, sprains, neurological impairment and even death. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor(s) to exercise judgment during the course of the treatment, which the doctor(s) feels at the time, based upon the facts then known to him/her, is in my best interest.

_____ I understand that Dr. Ryan and Dr. Silosky will use their hands or a mechanical device upon my body to adjust a joint, which may cause an audible “pop” or “click.”

_____ I understand that I am responsible for monitoring my own condition throughout the treatments and will inform the doctors of any unusual symptoms that might occur. In signing this informed consent form, I affirm that I have read this form in its entirety and that I understand the nature of the chiropractic treatment and procedures. I also affirm that all my questions regarding the chiropractic treatment, the management of my case, and the related risks to chiropractic treatment have been answered to my satisfaction.

_____ I have read, or have had read to me, the above consent, and by signing below, I fully understand and agree to the treatment recommended by Dr. Melissa Ryan and/or Dr. John Silosky. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment.

_____ I hereby acknowledge and agree that with full knowledge of the risks of treatment, I hereby for myself, my heirs, executors, administrators and personal representatives, waive, release and forever discharge Dr. Melissa Ryan and Dr. John Silosky, from and against all claims, actions, causes of action costs, expenses and demands by reason of any damage, loss, death or injury to my person or property arising out of or in connection with my participation in chiropractic care and other forms of treatment provided.

_____ _____

Athlete Signature (if 18 years of age or older) Date

Parent/Guardian Signature Date

Email: _____

Cell phone: _____