ST. MARY'S OF MICHIGAN
FIELD NEUROSCIENCES INSTITUTE

FNI

Athlete Waiver and Release Form

School: _____ Coach: _____
Player: _____ Birthday: _____
Gender: _____ Height: _____ Weight: _____
Sport(s): _____ Email: _____
Address: _____ City,St., Zip: _____

Please read carefully before signing:

The undersigned knows and understands that participating in athletics includes an element of risk. The TRAZER Baseline Assessment itself is an athletic event, and I understand that I (or my child) should not participate unless medically able. I assume any and all risks associated with this activity including, but not limited to injury during the assessment, illness, travelling to and from the assessment itself, and the condition of the premises.

Having read this waiver and knowing these facts, and in consideration of the benefits I will receive from participating, I hereby for myself, my heirs, executors, administrator or anyone else who might make claims on my behalf, covenant not to sue, and waive, release and discharge Field Neurosciences Institute, St. Mary's of Michigan, Ascension Healthcare, Traq Global Ltd, and their affiliates, officers, agents, employees, volunteers, and any other personnel in any way assisting or connected with this activity from any and all claims or liability of any kind or nature whatsoever arising out of my participation in this activity even though that liability may arise out of negligence or carelessness on the part of the persons or parties named in this waiver.

Further the undersigned consents and authorizes St. Mary's of Michigan on my behalf to obtain any necessary medical treatment or hospitalization or such other care necessary for the health and welfare of the named participant, and the undersigned agrees to be responsible for and pay the costs of such medical treatment or hospitalization.

The undersigned understands that the results of the TRAZER Baseline Assessment performed today will be provided to St. Mary's of Michigan Concussion Clinic (named Healthcare Provider) and that if I/my child suffers a sports injury, my/her/his baseline tests may be of value in my/her/his care and rehabilitation, and that I should consult with the named Healthcare Provider.

Contact Information for Parent/Guardian:

Daytime Phone:_____ Evening Phone:_____

Signature Participant:_____ Date:_____
Signature Parent/Guardian:_____ Date:_____
Name of Parent/Guardian:_____ Date:_____

Please list any conditions out team should be aware of that may impact your assessment session. Some accommodations can be made to improve accuracy.

_____

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