Black River MEMORIAL HOSPITAL Excellence. *Always.*

KROHN CLINIC OUR FAMILY CARING FOR YOURS

TIGERS

WISCONSIN RIVER ORTHOPAEDICS *Relieving pain and restoring lives*

Tiger Train & Gain

Class Registration and Waiver – 2017

Name: ____ Age: ___________ Entering Grade: ________

Address: ____________________________________ City: ______________________ Zip: ________

Primary Phone: ________________________________ Email: ________________________________

☐ Session 1 (Boys: 8:30am-10:45am) Mon/Thurs ☐ Session 3 (Girls: 8:30am-10:45am) Tues/Fri

☐ Session 2 (Boys: 9:45am-12:00pm) Mon/Thurs ☐ Session 4 (Girls: 9:45am-12:00pm) Tues/Fri

Release and Waiver of Liability

I understand that the Tiger Train & Gain will require my or my child's participation in physical activity, including, but not limited to, running, jumping, sudden stopping/starting, and weightlifting. I acknowledge that my or my child's participation in such activities can result in physical injury to me or my child and that the risk of such injury cannot be avoided.

In consideration of the information above and in order to participate, I agree:

- To assume full responsibility for any risk of bodily or personal injury, illness, death or property damage arising out of my or my child's own acts or omissions.

- **TO RELEASE, WAIVE, FOREVER DISCHARGE AND PROMISE TO HOLD HARMLESS BLACK RIVER MEMORIAL HOSPITAL, KROHN CLINIC, WISCONSIN RIVER ORTHOPAEDICS AND BLACK RIVER FALLS SCHOOL DISTRICT, AND ITS OFFICERS, DIRECTORS, AFFILIATES, EMPLOYEES, INSURERS, AGENTS, SUCCESSORS, AND ASSIGNS FROM ALL LIABILITY NOTWITHSTANDING THE NEGLIGENCE OF ANY OF THE PARTIES MENTIONED IN THIS PARAGRAPH BUT EXCLUDING LIABILITY ARISING OUT OF THE INTENTIONAL ACTS OR WILLFUL MISCONDUCT OF THE PARTIES MENTIONED IN THIS PARAGRAPH.**

- On behalf of my child and/or myself, I agree to indemnify and hold harmless Black River Memorial Hospital, Krohn Clinic, Wisconsin River Orthopaedics and Black River Falls School District from any and all claims connected with my participation or my child's participation in the activity.

- I have been given sufficient opportunity to read this document. My signature below acknowledges that I agree to be bound by the terms contained herein.

Signature of Parent/Guardian ____ Date _____________

Print Name ____

Signature of Participant (If 18 or older)_________________________________ Date _____________

Print Name ____

Return completed form and $50 payment to Jim Rufsholm (BRF Activities Director) or Dawn Jacobson (BRMH Athletic Trainer). Checks should be made out to Black River Memorial Hospital. For more information, contact Jim Rufsholm (715-284-4324) or Dawn Jacobson (715-284-1338)

Black River
MEMORIAL HOSPITAL
Excellence. *Always.*

Consent to Photograph/Interview/Video

I hereby consent to and authorize Black River Memorial Hospital and its agents, staff and representatives to make, use, edit, reproduce and publish any of the following (strike if not applicable): photographs, video, verbal comments, written comments, taped interview and other audiovisual records of me. I consent to and authorize the use of these items in the following manner (strike if not applicable): internal publications, community or public announcements, internet/website, email, social media, release to the media, and patient and medical professional education. This consent shall act to expressly release from liability Black River Memorial Hospital, any and all of its staff, its agents, representatives, consultants and physicians.

Name (printed) ____

I am over 18 years of age: ☐ Yes ☐ No*

______________________________ ______________________________
Signature of above-named person Witnessed by

Address______________________________ Date______________________________

____

Date______________________________

*If the above-named person is under 18 years of age or is otherwise unable to consent, consent should be given by parent or guardian as follows:

I hereby certify that I am the parent or guardian of ______________________________.

The person named above is unable to consent because ______________________________.

For the above-named person, I do hereby give my consent and authorization to the foregoing on behalf of him/her/them.

______________________________ ______________________________
Signature of guardian or parent Signature of witness

Thank you!