

Release and Medical Authorization

Please return this form with your application to The Colorado Spirit Office. **Participation is not allowed complete until this form is filed with the Spirit Coach.**

I understand that with any physical activity there is a risk of injury or even death. During my participation with the University of Colorado's Spirit Program, I accept any and all responsibilities for medical costs incurred by this activity. I accept the above risks and possible monetary costs and do not hold the University of Colorado or any of its representatives responsible for costs and or physical injury that I may receive during my tryout period.

In consideration of the University of Colorado granting the student permission to participate in official practices, performances, and appearances, I hereby assume all risks of his/her personal injury (including death) that may result from said activities. As a participant, I do identify, defend and hold harmless the University of Colorado, Board of Regents, State of Colorado, and the Colorado Spirit Office, its officers, employees, and agents against all liability; including claims and suits at law or in equity, for injury, fatal or otherwise, which may result from negligence and/or my participation in tryout/clinic activities.

In the event of injury or illness, I hereby give my consent for medical treatment and permission to a certified athletic trainer to supervise on-site first aid for minor injuries and to a licensed physician to hospitalize and secure proper treatment (including injections, anesthesia, surgery, or other reasonable treatment and necessary procedures) for the student.

Signature _____ Date _____

*****Every attempt will be made to contact Emergency # prior to medical attention****

Please PRINT all information except Parent/Guardian signature (Parent/Guardian signature is REQUIRED if student is under 18 years of age)

Student Name _____

SSN# _____ DOB _____

Parent/Guardian _____

Address _____ City _____

State _____ Zip _____ Home Phone _____ Work Phone _____

Date of Last Tetanus Immunization _____

Health Insurance CO. _____

Policy # _____

Parent/Guardian Signature _____ Date _____