MAYO CLINIC

Release and Waiver of Liability

Sports Medicine Center

TO BE SCANNED

This form collects information that is part of the medical record. **Route to Scanning.**

Mayo Clinic Number	Patient Name *(First, Middle, Last)*	Birth Date *(Month DD, YYYY)*

The risk of injury from participation in strenuous physical activity, including training, is significant, including the potential for serious injury and/or death. I knowingly and freely assume all such risks of participation in Mayo Clinic Sports Medicine Center Performance Solutions Program (SMCPSP), including but not limited to: reconditioning, performance planning, performance training (e.g., strength and conditioning training, speed and quickness training and plyometric training), sports nutrition consultation, and supplement and nutrition provision.

I certify that I have no health conditions that would prevent me from participating safely in the SMCPSP, and have had the opportunity to consult with my physician prior to registering for SMCPSP.

In consideration of being allowed to participate in the activities and programs of SMCPSP and to use its facilities and equipment in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge Mayo Clinic, Core Performance Centers LLC (CPC) and their respective officers, members, agents, employees, representatives, executors, and all others (Mayo Clinic and CPC representatives) from any and all responsibilities or liabilities from injuries or damages arising out of or connected with my participation in SMCPSP activities, my use of equipment, or any act or omission. I hereby acknowledge that my use of the Mayo Clinic Sports Medicine Center facilities and equipment and participation in activities and programs is at my own risk, and I assume and accept any and all risks of injury.

If I receive patient-related services during my participation in a SMCPSP, I understand that clinical information about those services may be documented in my Mayo Clinic medical record.

Attention

This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- If the patient is 18 years of age or older, the patient must sign and date the form.
- If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.

  Indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature (Required)	Date (Required) *(Month DD, YYYY)*

Printed Name of Person Signing (if not patient)