University of West Georgia Cheerleading Clinic
Physical Condition Certification
And
Waiver Statement

Release and Consent of Treatment:
I, the Parent/Guardian, do assume the responsibility for the participant being in good health and duly able to participate in any and all camp or clinic activities unless stated specifically in the activity exclusion section of this document. I, the Parent/Guardian, do assume responsibility for all fees and charges owing to emergencies or extended medical care. I, the Parent/Guardian, authorize a representative of the University to admit my child for medical treatment to Student Health Services at the University of West Georgia, private physician, Tanner Medical Center, or the nearest medical facility while visiting the University of West Georgia campus or participating in the clinic curriculum if in the opinion of the clinic director such referral is appropriate. UWG assumes no financial obligation for said referral. I, the Parent/Guardian, acknowledge that participation in a Cheerleading Clinic involves inherent risks of physical injury, illness or loss of personal property, and I assume all such risks. In exchange for participation in this Clinic, the undersigned does hereby release, waive, hold harmless, and forever discharge the Board of Regents of the University System of Georgia, the University of West Georgia, its agents, instructors, and employees from any and all claims or demands for injury or loss of property resulting from my child's participation in any activity included in the clinic curriculum or activities.

Name of Participant____

Participant Date of Birth____________________SSN_____________________

Printed name of Parent/Guardian____

Signature of Parent/Guardian____

I hereby certify that I have read the above carefully before signing.

Street Address____

City_______________________________State__________Zip______________

Home Phone____________________ Business Phone__________________ Email____________________

In case of emergency call____

Special medical problem(s) and Activity Exclusions:

Participant special health need or chronic health condition_______________________________

Participant has had this condition since____

Medications (please list medications, dosages, times taken, and side effects participant may experience from his/her medication)_____

Medications taken by participant during clinic must be registered with and administered by UWG Health Services.

____

____

Insurance Carrier_______________________________Phone____________________

Insurance Contract Number__________________________Group Number________________

Physician Information:

Name of Physician_______________________________Phone Number________________

Name of Dentist_______________________________Phone Number________________

Completed form must be presented to clinic staff prior to participation.