

**UNIVERSITY OF WASHINGTON
ASSUMPTION OF RISK RESPONSIBILITY WAIVER FOR:**

_____ **Print Legal Name Of Athlete**

**WOMEN'S NOVICE CREW
Sport**

I have been informed and fully understand that the University of Washington is **not** responsible in the event of an injury or illness incurred as a result of/or during an athletic tryout. I hereby waive all future claims against the University of Washington and specifically the Department of Intercollegiate Athletics, arising out of such an athletic tryout. I am aware that if medical care arising out of such an athletic tryout becomes necessary, it is my own responsibility to seek such care and I agree to assume full responsibility for any financial charges incurred.

I have been examined by a by a licensed Medical Doctor (MD), Physician Assistant (PA), Nurse Practitioner (LNP), or Doctor of Osteopathy (DO) and **will submit, prior to tryout**, a signed physical examination document. This document will verify that I am in good health and may participate without any restrictions.

My tryout period for **WOMEN'S NOVICE CREW** starts **SEPTEMBER 28th, 2011** and ends **OCTOBER 31st, 2011**. I do understand that if I am selected to become a member of a University of Washington team, I must undergo an Intercollegiate Athletic physical examination which will be administered by the ICA Medical Staff.

Check the following:

_____ I have no known medical conditions that would prevent me from participating in rigorous athletic activities.

_____ I have disclosed all medical conditions that may impact my ability to participate in rigorous athletic activities. They are the following: _____

In the unlikely event that I might be unable to provide information to the proper authorities, please refer to the following insurance information:

Insurance Plan Name: _____

*Subscriber Name: _____

*Subscriber's Phone Number: _____

*Subscriber ID#: _____

Group#: _____

Insurance Plan Phone#: _____

*Subscriber means the person who the plan is under (ie. mom, dad, you, etc)

***PLEASE HAVE PROSPECTIVE STUDENT-ATHLETE BRING A COPY OF THEIR MEDICAL INSURANCE CARD OR HAVE THEM BRING A COPY (FRONT AND BACK - ENLARGED TO 129%).**

_____ Date

_____ Signature

_____ Cell#

If under the age of 18, this form must be signed by a parent or legal guardian.

_____ Date

_____ Signature

_____ Relationship to Athlete

7/07

_____ Staff Initials/Authorization

THIS FORM MUST BE FILLED OUT IN BLUE OR BLACK INK!