CARLE SPORTS MEDICINE PERFORMANCE ENHANCEMENT REGISTRATION

Date: ____ / ____ / ____

Name: _____ _____ _____
First Middle Last

Address: _____
#/Street City State Zip

Date of Birth: ___/___/___ Sex (M/F) __ Home Phone _____ E-Mail: _____

School/Organization _____ Coach/Sponsor _____

What sport/activity will you be training for?
_____

What position or event? _____

What are your goals and expectations for this program (Please be as specific as possible)
_____
_____

Have you been injured recently? _____ If so, please explain type of injury and severity:
_____
_____

Are you currently taking or presently under any medication? _____ If so, please specify: _____
_____

Are you currently exercising? _____ If so, please describe duration and type of training:
_____
_____
_____

Is there any condition that might limit your participation in a training program? _____ If so, please explain:_____
_____

When does your sport/competition begin? _____

How did you hear about the program? _____

Persons registering for the program with you (if any). 1._____
2._____ 3._____ 4._____

I hereby acknowledge the above information is a prerequisite for my participation. I certify the information provided to be true and correct.

Signed: _____ _____
Participant Parent or Guardian (If participant is under 18)

FOR OFFICE USE ONLY

Program: _____ ATC: _____
Frequency: _____ Duration: _____
Cost: _____ Discount: _____ Payment Date: _____
Start Date: _____
Informed Consent: _____ Policy: _____ Waiver: _____ T-shirt Issued: _____
Results sent: _____ Follow-up Notes: _____ _____ _____ _____