

ONE-PAGE LIABILITY WAIVER + ASSUMPTION OF RISK + MEDICAL CONSENT  **READ CAREFULLY. THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS.**

PROGRAM/EVENT \_\_\_\_\_ DATE(S) \_\_\_\_\_

LOCATION \_\_\_\_\_

 **PARTICIPANT**

FULL NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_

PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

ADDRESS \_\_\_\_\_

 **PARENT/GUARDIAN (IF PARTICIPANT IS UNDER 18)** ☐ UNDER 18

PARENT/GUARDIAN NAME \_\_\_\_\_ PHONE \_\_\_\_\_

EMAIL \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

 **EMERGENCY CONTACT**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ RELATION \_\_\_\_\_

**1 ASSUMPTION OF RISK**

PVA activities may include athletic training, strength and conditioning, speed/agility work, sport drills, games, camps/clinics, mentorship activities, and use of facilities/equipment. I understand these activities have inherent risks including (but not limited to) sprains/strains, fractures, concussion, heat illness, dehydration, illness, permanent injury, paralysis, or death, and property damage. I knowingly and voluntarily assume ALL risks, known and unknown, to the fullest extent allowed by law.

**2 RELEASE OF LIABILITY**

In exchange for being allowed to participate, I release and waive any and all claims against Pro Vision Academy and its directors, officers, employees, contractors, coaches/trainers, volunteers, agents, sponsors/partners, facility owners/operators, and insurers ("Released Parties") for any injury, illness, death, or property damage arising from participation, including claims caused by the NEGLIGENCE of the Released Parties, to the fullest extent permitted by Washington law.

**3 INDEMNITY**

I agree to defend, indemnify, and hold harmless the Released Parties from claims, damages, or expenses (including attorney fees) arising from my/the participant's participation or conduct.

**4 MEDICAL FITNESS + EMERGENCY MEDICAL CONSENT**

I confirm the participant is physically able to participate and will follow all safety rules and coaching instructions. If injury/illness occurs, I authorize PVA to provide first aid and to obtain emergency medical treatment if needed. I understand PVA may not have medical staff on site. I am responsible for medical costs not covered by insurance.

MEDICAL CONDITIONS/ALLERGIES (IF ANY) \_\_\_\_\_

**5 CONCUSSION / HEAD INJURY**

I understand concussions are serious. The participant will report symptoms immediately and may be removed for safety. Return to activity may require medical clearance.

**6 PHOTO/VIDEO (CHECK ONE)**

- ☐ YES, I allow PVA to use photos/video for promotional/educational purposes.  
☐ NO, I do not allow photo/video use.

**7 RULES + REMOVAL**

I understand PVA may remove a participant for unsafe behavior or repeated rule violations.

**8 LEGAL TERMS**

Severability: If any part is invalid, the rest remains enforceable. Governing Law/Venue: State of Washington.

 **SIGNATURES**

ADULT PARTICIPANT (18+) OR PARENT/GUARDIAN (FOR MINOR) - PRINTED NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

MINOR PARTICIPANT (RECOMMENDED) - PRINTED NAME \_\_\_\_\_

MINOR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_