Tri-Masters
SPORTS INITIATIVE PROGRAMS
*Tri and you can master anything in life.*

CELEBRATING 25 Years

USA TRIATHLON
SANCTIONED EVENT

# TRI-MASTERS SPORTS INITIATIVE PROGRAMS
## "Get Ready To Tri" Summer 2017

## *Application*

---

Participant Name _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: ( ) _____

M _____ F _____ Age: _____ Date of Birth: _____

School _____

***Emergency Contact:***

Name: _____

Relationship: _____

Telephone: Home ( ) _____ Work ( ) _____

Address: _____

City: _____ State: _____ Zip Code: _____

In the event of an injury to this participant, Tri-Masters Sports Initiative Programs is authorized to obtain any medical care or treatment deemed necessary.

_____
Parent/Guardian Signature

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# EMERGENCY MEDICAL TREATMENT FORM

I hereby consent to and authorize the giving of Emergency Medical Treatment of my child _____ if needed, and to the release of such information suitable to treat my child while participating in the activities scheduled through the program above.

_____ _____

Parent/Guardian Signature Date

## Alternate Emergency Contacts if the parent/guardian cannot be reached:

Name: _____ Phone: _____

Relationship to Child: _____ _____

Name: _____ Phone: _____

Relationship to Child: _____ _____

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## INSURANCE QUESTIONNAIRE

Name of Student: _____

| Father | Mother |
|---|---|
| Name: _____ | Name: _____ |
| Employed: _____ Yes _____ No | Employed: _____ Yes _____ No |
| Company: _____ | Company: _____ |
| Address: _____ | Address: _____ |
| Phone: ( ) _____ | Phone: ( ) _____ |

Do you have group accident or hospital insurance to cover this athlete? ____ Yes _____ No

If you have medical insurance coverage, and your son/daughter is not covered or is partially covered due to policy limitations, please explain. _____

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I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATTE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE.

Parent/Guardian/Father: _____ Date: _____

Parent/Guardian/Mother: _____ Date: _____

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# TRI-MASTERS SPORTS INITIATIVE PROGRAMS
## "Get Ready To Tri" Summer 2017

## FIELD TRIP PARTICIPATION APPROVAL FORM

I hereby acknowledge my approval for _____
to participate in field trips including scheduled field training for participants in the Tri-Masters Sports Initiative Programs.

Signature _____ Date: _____

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## "Get Ready To Tri" Summer 2017

## PHOTOGRAPHIC RELEASE FORM

I hereby authorize the release of publicity/promotional photographs of the Tri-Masters Sports Initiative Programs that shows my child involved in program activities.

Child's Name _____ Age: _____

Parent/Guardian Signature _____ Date: _____

# TRI-MASTERS SPORTS INITIATIVE PROGRAMS
## "Get Ready To Tri" Summer 2017

### CHILD-PARENT COOPERATION AGREEMENT

### CHILD

I understand that I am expected to participate in scheduled program activities and to cooperate with teachers, staff, coaches and other children participating in the Tri-Masters Sports Initiative Program. I also understand that I may be dismissed from the program for being uncooperative or going against the rules set for the program, such as attendance, behavior, and attitude.

Child's Name (PRINT) _____ Age: _____

Child's Signature _____ Date: _____

### PARENT

I understand what is expected of my child in regard to attendance, behavior and attitude for participation in the Tri-Masters Sports Initiative Program. I will encourage my child to be cooperative and will be supportive of program staff in the application of rules, regulations and discipline policies. I understand that my child may be dismissed from the program for lack of cooperation or breaking the rules set for attendance, activities participation and general behavior.

Parent's Signature _____ Date: _____

# TRI-MASTERS SPORTS INITIATIVE PROGRAMS

## "Get Ready To Tri" Summer 2017

***MEDICAL EXAMINATION RECORD***

Enrollee name: _____ Telephone: ( ) _____
Last First M.

Address: _____ M ___ F ___ Age _____

_____ Birth date: _____/_____/____
Mo. Day Yr.

City: _____ State _____ Zip _____

---

Name of parent/guardian _____

Address of parent/guardian _____

Telephone: Home: ( ) _____ Work: ( ) _____

I understand that the medical examination will be required prior to the enrollment in this program. Further, in the event of injury or illness during the program, Tri-Masters Sports Initiative Programs is authorized to obtain any medical care or treatment deemed necessary for this participant.

_____
Parent/Guardian Signature

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Emergency Contact:

Name: _____ Relationship: _____

Telephone: Home: ( ) _____ Work: ( ) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Family doctor: _____ Telephone: ( ) _____

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Attention Medical Coordinator: Referral: A youth's parent or guardian must be informed of any health problem discovered during the screening process or during the course of the program. An appropriate health-care agency also will be informed with the parent's/guardian's consent. When a health problem is discovered that could limit participation in the planned activities, the youth may not be accepted in the program.
This confidential information should be made available only to the medical coordinator and physician.

Height: _____ Weight: _____ Pulse: _____ B/P: _____

List allergies: _____ Hemophilia: _____ other: _____

| | NORMAL | IF ABNORMAL DESCRIBE HERE | FOLLOW-UP | |
|---|---|---|---|---|
| Ears (hearing, absence of ceriman) | | | | |
| Eyes (reflexes, movements, visual acuity) | | | | |
| Nose, Throat, Sinuses | | | | |
| Gums | | | | |
| Teeth | | | | |
| Neck | | | | |
| Lungs | | | | |
| Breasts | | | | |
| Lymph Nodes | | | | |
| Heart | | | | |
| Absence of Hernia | | | | |
| Back | | | | |
| Bones, Joints and Muscles | | | | |
| Nervous | | | | |
| | | **OPTIONAL** | | |
| Chest X-Ray | | | | |

Sickle Cell Prep _____ Urine Albumin _____ Urine Sugar _____ Hb. _____

Immunization Record: Tetanus _____ Booster Needed Yes [ ] No [ ]
Date

Diphtheria _____ Booster Needed Yes [ ] No [ ]
Date

Polio _____ Booster Needed Yes [ ] No [ ]
Date

General Physical Condition: _____

May Participate in Program Yes [ ] No [ ]

Additional comments or recommendations: _____