

**TENNIS PARTICIPANT RELEASE OF LIABILITY, WAIVER OF CLAIMS,
EXPRESS ASSUMPTION OF RISK AGREEMENT**

Player Name: _____

Age: _____ Address: _____ City: _____ Zip: _____

Parent/Guardian Name(s): _____

Home Phone: _____ Work phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Child's Doctor: _____ Phone: _____

Existing Medical Coverage: _____ Plan #: _____

Known Allergies:

(includes medicine, food, bee stings, etc.)

Current Medications AND OR Medical Conditions: (or any related information that would assist in safe treatment)

Liability Waiver and Medical Release: I hereby permit my child to participate in taking tennis lessons from Robert A. Mize and or Avon Community Tennis Association (known as the Avon CTA). I understand and fully accept that there are risks involved in sports, and that accidents and injuries are common ordinary occurrences of sports. These injuries could include, but are not limited to: knee injuries, abrasions, pulled muscles, injuries caused by being struck by a ball or racquet, injuries to the spine, neck injuries, heart attacks, etc. I hereby release and hold harmless Robert A. Mize, the Avon CTA, any workers or volunteers from all liability, and from all actions or claims that I or my child now or hereafter have for damage or injury to my child, or to any person or property, resulting from the negligence or other acts by any volunteers or workers in connection with my child's participation in these tennis lessons. I understand and agree that it is my sole responsibility to make certain that my child/children is/are physically healthy and fit to participate in the activities and programs offered by Robert A. Mize and or the Avon CTA.

In case of a medical emergency, I hereby give permission to Robert Mize, the Avon CTA, and their instructors to order treatment for my child if an attempt to contact me is not successful and medical personnel have informed Mr. Mize, the Avon CTA, and their instructors that a medical procedure is absolutely necessary. This includes any necessary medical treatment, x-rays, or emergency care.

I understand that an attempt will be made to reach me by phone when a diagnosis is completed. I also understand that all related medical costs are my responsibility.

Print Name: _____

Parent or Guardian Signature: _____

Date: _____