

ATHLETE INFORMATION

Last Name _____ First Name _____ Middle Initial _____

CONFIDENTIAL INFORMATION CONTAINED HEREIN WILL NOT BE RELEASED WITHOUT WRITTEN AUTHORIZATION.

1. Please check any of the following conditions/illnesses that the participant (you/your child) has or has had in the past:

- | | | |
|--|--|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Dizzy spells/fainting | <input type="checkbox"/> Kidneys |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Drug allergies | <input type="checkbox"/> Knees (i.e. injury, swelling, etc.) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Numbness or tingling in extremities |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Eyes (except glasses) | <input type="checkbox"/> Operations or surgery |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Headaches (requiring treatment) | <input type="checkbox"/> Other major injuries |
| <input type="checkbox"/> Breathing (i.e. asthma) | <input type="checkbox"/> Hearing / ear problems | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Heart | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Spine (back or neck) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint pain or swelling | <input type="checkbox"/> Varicose veins |

2. Please check any of the following muscle, tendon, bone or joint problems:

- | | | | | |
|--------------------------------|----------------------------------|-------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hand | <input type="checkbox"/> Neck | <input type="checkbox"/> Toes |
| <input type="checkbox"/> Back | <input type="checkbox"/> Fingers | <input type="checkbox"/> Head | <input type="checkbox"/> Shin | <input type="checkbox"/> Upper arm |
| <input type="checkbox"/> Calf | <input type="checkbox"/> Foot | <input type="checkbox"/> Hip | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Forearm | <input type="checkbox"/> Knee | <input type="checkbox"/> Thigh | |

3. Please provide details for all checked items in Questions 1 and 2, including dates of occurrence:

- | | | |
|--|------------------------------|-----------------------------|
| 4. Has the participant ever been knocked unconscious and/or had a seizure? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Has the participant ever had a cervical spine injury? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Is the participant currently under a physician's care? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Is the participant currently taking any medications or drugs? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Is the participant currently taking any supplements? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Does the participant have a permanent handicap or disability? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Has the participant ever become ill from exercising in the heat? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

If answered YES to any question 4 – 10, please identify question number and provide details and any pertinent information:

Is there any other medical condition that BlueStreak should be aware of?

ATHLETE INFORMATION

Last Name _____ First Name _____ Middle Initial _____

ACKNOWLEDGEMENT AND RELEASE

I _____ (participant) and _____ (parent/guardian if participant is under age 18), in consideration for my participation in the Chelsea Piers BlueStreak ("CP BlueStreak") Sports Training Program(s) ("the Program") offered by Chelsea Piers LP, do hereby understand and agree to the following:

1. Payment in full is required prior to the commencement of the first session of the Program and no cash refunds will be given if I fail to complete the program. All training fees are non-refundable.
2. Under CP BlueStreak's no-show policy, I understand that if I miss a training session or am ten (10) or more minutes late for a scheduled session, I will forfeit a paid session. Cancellations must be made at least one full day in advance.
3. CP BlueStreak and its employees or agents cannot guarantee or warrant that participation in the program will improve or enhance my performance or physical condition. Results may vary based on individual athletic ability and effort.
4. CP BlueStreak may collect and obtain data as a result of my participation in the Program and use such information in reports or publications. My identity may be used in advertisements for CP BlueStreak, including, but not limited to, DVDs, videos, brochures, posters, signs, e-mail blasts and website programs.
5. I declare that I have no known medical problems that would preclude my participation in the Program, and the information provided to CP BlueStreak regarding my medical history and physical condition is, to the best of my knowledge, true and correct.
6. My participation in the CP BlueStreak Program is voluntary and I assume all risk of injury or contraction of any illness or medical condition that may result, or the aggravation of any pre-existing medical condition I may have. I also assume the risk of any damage, loss or theft of any personal property resulting or arising out of my participation in the Program.
7. I understand and acknowledge that CP BlueStreak has no expertise in diagnosing, examining, or treating any medical condition, whether

existing or incurred as a result of my participation in the CP BlueStreak program.

8. I hereby authorize and consent that my physical condition be examined and evaluated by a physical therapist from Performance Physical Therapy to determine if, and to what extent, medical attention may be advisable or required. I hereby release and discharge said physical therapist and Performance Physical Therapy, Chelsea Piers BlueStreak, Pier 60, its agents, servants and/or employees from any and all liability arising out of or as a result of said examination and evaluation. If I am under the age of 18 years, the signature of my parent or guardian appears below to acknowledge, approve and confirm this authorization and consent.

I hereby, on behalf of myself, my personal representatives, heirs, executors, administrators, agents and assigns, forever release and discharge CP BlueStreak, its affiliates, employees, agents, representatives, successors, and assigns from any and all claims or causes of action (known or unknown) that I may now have or will have in the future as a result of my participation in the Program. This waiver and release of liability includes, but is not limited to, injuries that result from my use of any exercise equipment or facilities provided by BlueStreak, and any injuries which occur on CP BlueStreak premises or equipment.

I have carefully read this waiver and release and fully understand that it is a complete release of liability, that I hereby waive any right that I may now have or will have to bring any legal action against CP BlueStreak, its employees, agents, successors or assigns, for any liabilities that may result, whether directly or indirectly, from my participation in the Program.

The provisions in this document are severable and if any provision is determined to be illegal or unenforceable, the remaining provisions and any partially enforceable provisions shall nevertheless be enforceable unless otherwise prohibited by the laws of the State of New York. CP BlueStreak's failure to enforce any remedy or provision of this document shall not be construed as a waiver of such remedy or provision.

MEDICAL TREATMENT

I hereby give permission for my son/daughter to undergo medical treatment for any injury or illness he/she may sustain or acquire while engaged in the Chelsea Piers BlueStreak program. I understand that the personnel of Chelsea Piers BlueStreak use only those procedures which are within their training, credentialing and scope of professional practice to prevent, care for and rehabilitate injuries. In the event that more serious medical procedures are required, such as surgery or other invasive procedures, I understand that attempts will be made to contact me for my consent. I understand that if my child suffers a potentially life threatening injury or illness, and in the event I am unable to be contacted within a reasonable period of time, that I authorize any duly licensed medical practitioner to perform such procedures as may be medically necessary to alleviate the problem.

I have had the opportunity to ask questions regarding this release and all of my questions have been answered to my satisfaction. Having understood the above agreement, I freely sign this Permission to Provide Medical Treatment Agreement.

I acknowledge that the participant is under the age of 19. I have reviewed the information provided and certify it to be true and correct.

I consent to my son/daughter participating in the Chelsea Piers BlueStreak program.

By signing below, I acknowledge that I have carefully read and fully understand this acknowledgment and release and medical treatment agreements.

Parent/Guardian Signature _____ Print Name _____ Date _____

CHELSEA PIERS BLUESTREAK