Council on Sports Injuries
Physical Fitness & Rehabilitation

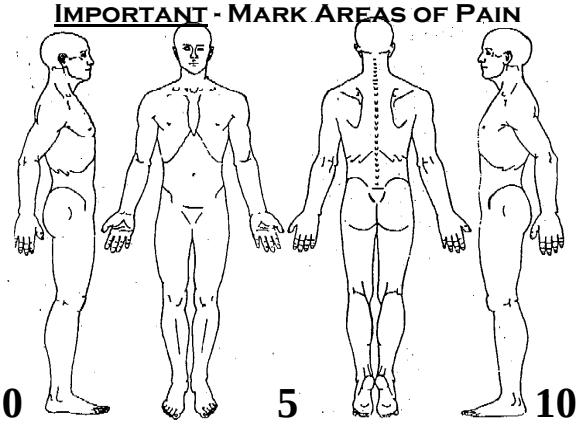
EVENT ENTERED: _____ EVENT SITE (CITY): Miami, FL

NAME:_____ AGE _____ HOME PHONE ( )_____

ADDRESS:_____CITY_____ST_____ZIP_____

HAVE YOU EVER HAD/BEEN?	Y	N	DOCTOR'S COMMENTS
HEAD INJURY			
KNOCKED OUT			
SEIZURE			
FRACTURE			
HOSPITALIZATION			
SURGERY			
MRI OR CT SCAN			
HIGH BLOOD PRESSURE			
SPORTS-RELATED DIZZINESS			
CHEST PAIN			

IMPORTANT - MARK AREAS OF PAIN



0 5 10

No Pain — HOW BAD IS THE PAIN — Severe Pain

INFORMED CONSENT WAIVER & AUTHORIZATION TO TREAT

I, the undersigned, acknowledge by my signature, that I am aware of the participating treating Doctor of Chiropractic (D.C.) listed below, that he/she is a licensed chiropractor, and though rare, injury resulting from manipulation may include stroke, death, disc herniation and other injuries or complications.

I hereby agree to hold the Florida Chiropractic Association – Council on Sports Injuries, Physical Fitness & Rehabilitation; the Florida Chiropractic Association and it's affiliates; and any and all associated co-sponsorships of any level of participation free and harmless from any liability, claims, demands, or suits for damages from any injury or complication whatever, which may result from such treatment. This document is binding and the parties hereunto intend this **Informed Consent Waiver and Authorization to Treat** to be binding on and inure to the benefit of their respective principals, heirs, executors, administrators, successors and assigns; includes any and all my successors and/or heirs. I further state that should complications arise from such agreed treatment with treating Doctor of Chiropractic that such individual and myself will be the only parties to engage in any and all recourse should that need arise foregoing any and all others.

SIGNATURE:_____EVENT ID#_____DATE:___/___/___

DOCTOR'S NOTES — LEVEL(S) OF TREATMENT

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0 5 10

No Pain — LEVEL OF PAIN AFTER Tx — Severe Pain

ATTENDING DOCTOR OF CHIROPRACTIC

PRINT NAME_____LICENSE #CH_____