FAST Authorization for Medical Treatment and Unconditional Release

Effective Date: September 1, 2024

CONFIDENTIAL

Name of Participant:_____

Name of Parent(s) / Guardian(s) if Participant is a Minor:_____

Participant's Address:_____

Phone Numbers: (Home)_____ (Cell)_____

Medical insurance carrier and policy #:_____

_____

Contact information for primary care physician:_____

_____

Current Medications used by athlete/ coach/ staff:_____

_____

Known allergies:_____

_____

Prior injuries or conditions:_____

_____

I understand that the sport of diving has inherent risks, including serious physical injury or death.

Although FAST ("FAST") has taken reasonable and prudent steps to reduce foreseeable risks, they still exist. Accordingly, in exchange for allowing me to participate in any USA Diving event, AAU event, FAST event, FAST team trip or activity (the "Event"), I (and my parent(s) or legal guardian(s) if I am under 18 years old) agree to each of the following. The term "I" in this document refers to both me and my parent(s) or legal guardian(s).

1. I AM AWARE AND UNDERSTAND THAT THE EVENT IS DANGEROUS AND INVOLVES THE RISK OF SERIOUS PERSONAL INJURY, BODILY INJURY, PARALYSIS, DEATH, OR PROPERTY LOSS OR DAMAGE. I ACKNOWLEDGE THAT ANY INJURIES OR LOSSES THAT I SUSTAIN MAY BE COMPOUNDED BY THE NEGLIGENCE OF OTHERS, INCLUDING EMERGENCY RESPONSE OR RESCUE OPERATIONS. I AM VOLUNTARILY PARTICIPATING IN THE ACTIVITY WITH KNOWLEDGE OF THE DANGER INVOLVED AND HEREBY ACCEPT AND ASSUME ANY AND ALL RISKS OF INJURY, PARALYSIS, DEATH, OR PROPERTY DAMAGE.

2. I authorize FAST and its representatives to provide to me, through medical personnel of their choice, customary medical assistance, transportation, first aid, and emergency medical services (collectively "Treatment") if I require such Treatment as a result of injury or damage related to, or suffered during, the Event. If I am a minor and my parent or guardian is not present, FAST and its representative will make reasonable efforts under the circumstances to contact my parent or guardian, but Treatment will not be withheld if my parent or guardian cannot be reached. This authorization does not impose a duty upon FAST or its representatives to provide such Treatment. I assume financial responsibility for all such Treatment. I knowingly give this authorization before any Treatment.

3. I release and forever discharge FAST, its officers, directors, employees, members, contractors, staff, agents, and representatives, from any and all liabilities, claims, demands, actions, or causes of action of any kind or character arising out of or in connection with the Event, including without limitation any injury to person (including death) or property resulting from, or occurring before, during, or after the Event, whether in the United States or a foreign country, as well as for any medical treatment.

4. This document is binding on my relatives, personal representatives, heirs, beneficiaries, next of kin, or assigns and shall inure to the benefit of FAST and its respective directors, officers, employees, agents, staff, contractors, volunteers, successors, and assigns. If any provision (or portion of any provision) of this document is held to be invalid or unenforceable, that provision shall be enforceable in part to the fullest extent permitted

by law, and such invalidity or unenforceability shall not otherwise affect any other provision of this document. This document will be governed by Indiana law, except for its choice of law rules.

THIS IS A CONSENT TO MEDICAL TREATMENT AND RELEASE OF LIABILITY. I HAVE READ AND UNDERSTAND THE ENTIRETY OF THIS AUTHORIZATION FOR MEDICAL TREATMENT AND UNCONDITIONAL RELEASE. I AM SIGNING THIS AUTHORIZATION FOR MEDICAL TREATMENT AND UNCONDITIONAL RELEASE VOLUNTARILY.

Signature of Participant:_____ Date:_____

If the person participating in the Program is not yet 18 years old, one of his/her parents or legal guardians must sign.

IN EXCHANGE FOR MY/OUR CHILD BEING ALLOWED TO PARTICIPATE IN THE EVENT, AND AS THE PARENT OR LEGAL GUARDIAN OF THE ABOVE-NAMED PARTICIPANT, I VERIFY THAT I FULLY UNDERSTAND, AGREE TO, AND ACCEPT ALL PROVISIONS OF THIS AUTHORIZATION FOR MEDICAL TREATMENT AND UNCONDITIONAL RELEASE. I AM SIGNING ON BEHALF OF MYSELF AND AS AN AGENT FOR ANY OTHER INDIVIDUAL WHO MAY BE A PARENT OR GUARDIAN OF MY CHILD. I AM FULLY AUTHORIZED TO DO SO, AND BY EXECUTING THIS AUTHORIZATION FOR MEDICAL TREATMENT AND UNCONDITIONAL RELEASE, I AM BINDING MYSELF, ANY OTHER PARENT OR GUARDIAN OF MY CHILD, AND MY CHILD.

Signature of Parent(s) or Guardian(s), if participant is a minor:

_____ Date:_____

_____ Date:_____