RXN™ ATHLETICS

APPLYING SCIENCE TO YOUR GAME

DEMOGRAPHIC FORM

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (____)_____ E-Mail: _____

Gender: _____ Birth Date: _____

Emergency Contact: _____ Emergency #: _____

Informed Consent / Liability Waiver

I understand that there is an inherent risk of injury, whether caused by me or someone else, in the use of or presence at RXN Athletics, LLC. (herein afterward referred to as RXN), the use of equipment and services at RXN, and participation in RXN's programs. This risk includes, but is not limited to:

- *Injuries arising from the use of any of RXN's equipment or facilities*
- *Injuries arising from participation in supervised or unsupervised activities and programs within RXN or outside, to the extent sponsored or endorsed by RXN*
- *Injuries or medical disorders resulting from exercise at RXN, including, but not limited to heart attacks, strokes, broken bones, and torn muscles or ligaments*
- *Injuries resulting from the actions taken or decisions made regarding medical or survival procedures*

I understand and voluntarily accept this risk. I agree to specifically assume all risk of injury, whether physical or mental, as well as all risk of loss, theft, or damage of personal property for me, any person that is a part of this facility and any guest while such persons are using or present at RXN, using any lockers, equipment, or services at RXN, or participating in RXN's programs, whether such programs take place inside or outside of RXN's facility. While using RXN's facilities, I hereby so declare myself to be physically sound, having medical approval by a licensed medical physician to participate at the RXN facilities.

I hereby accept all risk to my health and injury or death that may result from such participation and I hereby release RXN, its officers, employees, and any representatives from any liability to me, my personal action for loss of or damage to my property and for any and all illness or injury to my person, including death, that may result from or occur during participation in the RXN facility, whether caused by negligence of RXN, its officers, employees, or representatives, or otherwise. I further agree to indemnify and hold harmless RXN and its officers, employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from my negligent or intentional act or omission while participating in the RXN facility.

_____	_____	_____
Signature of Participant or Guardian	*Print Name*	*Date*

IN YOUR NEIGHBORHOOD
2270 Joe Battle Blvd. Suite T | El Paso, TX 79938
Tel: (915) 857-7588

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RELEASE FORM

RXN™ ATHLETICS

Medical History

Have you ever experienced, or do you have any known cardiovascular, pulmonary, or metabolic diseases including, but not limited to: High blood pressure, diabetes, asthma, heart murmur, peripheral vascular disease, arrhythmias? ☐ Yes ☐ No

If so, please describe:

_____

Do you have any family history of heart disease? ☐ Yes ☐ No

If so, please describe:

_____

Are there any other medical conditions you have that should be made aware to RXN Athletics which may be dangerous to your health while engaging in exercise? ☐ Yes ☐ No

Please list: _____

_____

Do you take any prescribed medications on a regular basis? ☐ Yes ☐ No

Please List: _____

_____

Please list any drug or other allergies you may have:

_____

I understand that it is my responsibility to disclose my medical history, and I have done so to the best of my ability.

_____ _____

Signature of Participant or Guardian *Date*

Consent for Video/Photo and/or Interview

I voluntarily give my permission for photographs, videos, or digital images to be taken of me at RXN. I understand that the photographer(s)/videographer(s) may or may not be employed RXN staff, and that the photographer(s)/videographer(s) may be a member(s) of the media. I give my consent to publish any photographs, videotapes, videos, or digital images of me without incurring any debts or liabilities to me. I understand the nature of the photography session and understand that I will receive no compensation or fee either now or in the future for this session or for resulting images published, aired and/or electronically transmitted. I give permission voluntarily and have full authority to give this consent. The photo(s)/image(s)/video(s) may be used in one or more of the following: news media, internal RXN publications, newsletters, direct mail, website, or other promotional materials. This authorization is in effect until further notice. I understand that I may revoke this authorization, in writing, at any time. However, I understand once photography materials are released to the news media, RXN retains no further control over their use. I understand that I am not required by RXN to sign this authorization form and that authorization is not a condition for me to receive continued service at RXN.

_____ _____ _____

Signature of Participant or Guardian *Print Name* *Date*

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