Ascension Via Christi Sports Medicine Program may contact the Privacy Officer at Ascension Via Christi Health.

EXHIBIT B

LIABILITY WAIVER

Please print legibly.

Last Name:	First Name:
Phone #:	Email Address:
Home Address:	
☐ Female ☐ Male	Age:

I understand I should consult with my personal healthcare provider if I have any concerns regarding participating in the Athletic Trainer Outreach Program, as more fully described in the Athletic Trainer Outreach Event Contract between Unified School District 266 and Ascension Via Christi Rehabilitation Hospital, Inc. I acknowledge that my participation in this event involves a risk of injury, including bodily injury, and assume the risk for same. On my own behalf and on behalf of my heirs and legal representatives and to the fullest extent permitted by law, I hereby release, waive, absolve, discharge and agree to hold harmless Ascension Via Christi Rehabilitation Hospital, Inc. and their respective directors, officers, employees, affiliates, members, agents and representatives, of and from any and all liability for injury, death, or damages and/or any other claims, demands, losses or damages, incurred by me in connection with any aspect of the Athletic Trainer Outreach Program.

I HAVE READ THIS RELEASE AND WAIVER OF LIABILITY, UNDERSTAND IT, VOLUNTARILY AGREE TO IT, AND FURTHER UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT.

Signature:	Date:
Signature of Parent/Legal Guardian: (If participant is less than 18 years old)	
Relationship to Participant:	Date: