



## **DAKOTA WESLEYAN UNIVERSITY**

**Athletic Training Department**  
1200 W. University Ave., Mitchell, SD 57301  
(605) 995-2144

### **Shared Responsibility for Sport Safety**

While benefits from intercollegiate athletic participation may be great, there are also potential risks involved in competition and preparation for competition. The responsibility of sport safety is a shared effort between administrators, coaches, physicians, athletic trainers and student-athletes.

Both participants and parent(s) are hereby advised that participation in athletics may lead to injuries and bodily harm including the possibility of permanent physical or mental disability, partial or complete paralysis or death. I understand this signature does not absolve Dakota Wesleyan University's responsibilities to me. This statement is intended to inform me of the potential risk associated with sports participation and it is my responsibility to help prevent injuries, comply with DWU athletic sports medicine staff, and be aware of such risks.

I have read the above shared responsibility for sport safety statement and acknowledge that I am willing to assume responsibility for such risks while participating in athletics at Dakota Wesleyan University. In the event that medical care is needed, I have primary insurance coverage in effect and will take responsibility to keep my private policy premiums paid while I am a student athlete. I understand that Dakota Wesleyan University offers excess insurance that can be billed for remaining medical expenses after my primary insurance has been processed. I also understand any medical care balance remaining after insurance has been processed is my responsibility to pay. I am aware that if I let my primary insurance lapse for any reason, I will be ineligible to participate in practice or collegiate competition.

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Athlete's Name (Please Print)

Athlete's Signature

Date

### **Medical Consent**

I hereby grant permission to Dakota Wesleyan University ("DWU") team and school physicians and sports medicine staff and other physicians designated by DWU to provide me with any medical care, treatment, first-aid, rehabilitative, or emergency treatments they deem necessary to my health and well-being, including injuries and medical conditions occurring as a result of or during DWU athletics.

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Athlete's Name (Please Print)

Athlete's Signature

Date

### **Parental Permission (if athlete is under 18 years of age)**

I hereby give my consent for my minor son or daughter or ward to practice and play in intercollegiate athletic events at Dakota Wesleyan University. I also hereby understand the consequences of participation in athletics and the possible need for medical care as described in the statements above and agree to these principle statements.

I also grant permission for treatment deemed necessary for conditions arising during participation in those activities, including medical or surgical treatment recommended by a medical doctor. I understand that in the event of an emergency, every effort will be made to contact me before treatment.

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Parent Name (Print Please)

Parent Signature

Relationship

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Address

Date