HIGH PERFORMANCE SUPPORT PROGRAM
CONSENT & MEDICAL DECLARATION FORM

WAVERLEY Gymnastics Centre

Please click here or scan to read the full Sports Science and Medicine Policy.

CONSENT FORM

I have read and agree to the *WGC Sports Science and Medicine Policy* and consent to participation in Sports Science Sport Medicine treatment sessions and/or training at WGC.

I understand as an over 18 gymnast a second adult is not required to supervise my appointments; however, I am aware I can elect to have a second adult e.g. parent or guardian attend my appointments at any time.

I understand (if training in one of the following squads Int 1, Nat 1, Int 2, Dev 1, Limited) I may be given access to the on-site WGC Recovery and Wellness Room and I may utilise the hot/cold plunge pools and massage chairs. I understand I am not able to use the hot/cold plunge pools without supervision from a WGC coach or staff member.

I understand I must adhere to the WGC Recovery and Wellness Room Procedure *(located within the full WGC Sports Science and Medicine Policy).*

I consent to participating in all additional WGC support programs including Ballet, Pilates, Strength and Conditioning, Nutrition Workshops and Mental Fitness Training.
Please note support programs allocated to each squad will depend on gymnast's age and training hours.

I consent to WGC communicating directly with relevant medical staff (e.g. WGC physiotherapists) regarding any injury or illness I have or may sustain and for the relevant medical staff to disclose to WGC coaches and relevant HP personnel relevant information about this injury or illness.
In doing so, this enables WGC to provide you with the most effective and efficient injury management to best support your training. You may withdraw consent at any time via written notification to the HP Manager.

Your Name:____

Signature:____

Date: / /

I consent to a student physiotherapist or myotherapist attending my appointments on occasion.	
YES ☐	**NO ☐**

PREFERRED APPOINTMENT TIME NOMINATION FORM

I have the following preferred appointment times:

WEEKDAY	AM TIMES	PM TIMES
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		

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MEDICAL DECLARATION

Athlete Name: ____________________________ DOB: / / 20 Date: / / 20

Emergency Contact: ______________________

Relationship to child: _____________________ Phone Number: 04

Does your child have or ever experienced the following (please tick yes or no):	**YES**	**NO**
Any previous concussions?		
Diabetes		
Epilepsy		
Dizziness or fainting		
Asthma or respiratory problems		
Previously sustained injuries: If yes, please list:		
Connective tissue disorder (or family history) e.g., ehlers danlos If yes, please specify:		
Soft tissue damage e.g., meniscal, tendon, ligament If yes, please specify:		
Previous broken bones or metal work If yes, please specify:		
Previous operations If yes, please specify:		
A bone, joint, or muscular problem or arthritis If yes, please specify:		
Allergies If yes, please list:		
Is your child taking any medication e.g., antibiotics, pain killers. If yes, please list:		

Please provide any relevant imaging reports or medical letters from previous injuries when returning this signed consent form.