



## Gallatin Roller Girlz Pregnancy Acknowledgement of Risks and Indemnification

Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Black Diamond Skater: Y N

I acknowledge that I am pregnant and that I am a black diamond level skater and I choose to continue my participation in Gallatin Roller Girlz roller derby skating program, in a strictly non-contact manner until the end of my first trimester. Skaters that have not achieved their black diamond status – an advanced skill level assessment - may not skate while pregnant. After the first trimester absolutely no skating for any ability skater is allowed by Gallatin Roller Girlz. Skaters may choose at this point to stay active with the league in a non-skating capacity (coaching, NSO, etc). Skaters may also choose to take a Leave of Absence. Please refer to the Leave of Absence policy for additional details.

I understand that there are potential risks involved in any exercise activity. I also understand that I could experience muscle, back, or bone injuries during exercise. To my knowledge, I do not have any limiting physical conditions, which would prevent me from participating in the program. I release Gallatin Roller Girlz from any liability if I experience any physical problems as a participant in the roller derby program, and I waive any right, actual or presumed, to bring a cause of action against Gallatin Roller Girlz if I have any physical problems (injuries, illness, or other complaint) as a participant.

I've been informed that I must have a physician's approval to participate on skates in a non-contact manner and that the letter must accompany this release. I also understand that if I experience changes in my health during the prenatal period, I must notify GRG and provide another physician approval. I accept complete responsibility for my health and well being in the roller derby skating program and understand that no responsibility or liability is assumed by the Gallatin Roller Girlz.

\_\_\_\_\_  
 Signature of Participant Date

**Please complete:**

What is your due date? \_\_\_\_\_  
 End of First Trimester Date: \_\_\_\_\_  
 Name of Doctor: \_\_\_\_\_ Doctor's Phone #: \_\_\_\_\_  
 Doctor's Practice: \_\_\_\_\_ Doctors Note: Y N