

# KIPP®

Knee Injury Prevention Program

## GROUP KIPP FOR COACHES ENROLLMENT FORM

By enrolling your organization's coaches in **KIPP for Coaches**, you acknowledge the following:

- (1) The program is designed for coaches of female athletes 13 years of age and older.
- (2) Each coach will attend a two-hour training session. Date, time and location to be mutually agreed upon.
- (3) Each coach will receive a KIPP Tool Kit containing a course syllabus with scientific literature about the benefits of neuromuscular training, a laminated card containing a list of exercises for each practice day and game day and an instructional DVD.
- (4) Each coach will be required to sign a consent form to participate.
- (5) Each coach will be invited to participate in our research by completing a one-page pre- and post-test, and a course evaluation.
- (6) The total enrollment fee is based on the number of coaches:

<u>Fee per coach</u>	<u>Number of coaches</u>
\$125	5-7
\$100	8-11
\$90	12-14
\$80	15 or more
- (7) A minimum of 5 coaches is required to schedule a training session. If fewer than 5 coaches attend the training session, the minimum total enrollment fee of \$625 will be charged.
- (8) A deposit of \$625 is due at the time of enrollment to reserve instructor(s) time and necessary materials for training session.
- (9) Final payment of remaining balance is due within 30 days of receipt of invoice. An invoice will be sent to the designated representative for the organization.
- (10) For cancellations received two or more weeks before the training session, the enrollment fee will be refunded, minus a \$30 processing fee.
- (11) For cancellations received less than two weeks before the training session, the enrollment fee will not be refunded.
- (12) Participation in KIPP does not guarantee or ensure that your athletes will never be injured in the future as a result of sports activity.
- (13) As with any exercise program, there is a risk of tripping, falling, muscle strain or other sports injury during KIPP, but such risk is no more than what is expected in normal sports activity.

I (please print), \_\_\_\_\_, as the designated representative for

\_\_\_\_\_ (name of the organization) and hereby agree to the payment terms and cancellation policy described.

Signature of designated representative: \_\_\_\_\_ Date: \_\_\_\_\_

Fax completed form to 773.327.1166 or mail to: Institute for Sports Medicine, Attn: Laverne Head, Children's Memorial Hospital, 2300 Children's Plaza, Box 69, Chicago, IL 60614



The Institute for Sports Medicine is comprised of a team of specialists with expertise in the treatment and prevention of the sports-related injuries and medical conditions unique to children and adolescents.