



DIRECT CONTACT CONSENT

By offering my name and contact information to the Disabled Athlete Sports Association (DASA), I understand that a DASA representative will contact me about the programs and services DASA offers. I understand that DASA services are fee-based and not covered under insurance. I understand that my name and contact information will not be disclosed or shared with any other entity outside of DASA unless additional authorization is obtained from me.

PERSON TO BE CONTACTED

FIRST & LAST NAME: _____

STREET ADDRESS: _____ **APT:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

DOB: _____ **EMAIL:** _____ **PHONE:** _____

PREFERRED CONTACT METHOD: PHONE: _____ **EMAIL:** _____

DESIRED DATE OF FIRST CONTACT: _____

NAME & RELATIONSHIP TO INDIVIDUAL ABOVE (IF DIFFERENT): _____

SIGNATURE: _____ **DATE:** _____

Release is valid for one year from the date of signature.

Please indicate which DASA programming and services you have an interest in learning more about:

Adaptive Sports & Fitness: _____ Ability Gym Adaptive Training: _____

Administrative Use Only

FORM COMPLETED: _____ **IN PERSON:** _____ **PHONE CALL:** _____

NAME OF REPRESENTATIVE: _____

EMAIL: _____ **PHONE:** _____

ORGANIZATION/GROUP AFFILIATION (IF APPLICABLE): _____

Please send completed form to dasa@dasasports.org, or mail to **1600 Mid Rivers Mall, Suite 2272, St. Peters MO, 63131**