SCTP Program℠ Medical Consent Form

Team Name (required): ____

Athlete's Name: ____
(Please PRINT)

Address: ____

In the event that the Athlete may require emergency medical care, or in the event Athlete may become ill, while participating in the Scholastic Clay Target Program, Athlete (and Athlete's parent/legal guardian if Athlete is a minor) hereby gives advanced consent to the Scholastic Shooting Sports Foundation, SCTP® Sponsors and Governing Bodies, including their respective volunteers, to provide, through a medical staff of their choice, necessary or advisable medical care and treatment to Athlete.

Athlete (and Athlete's parent/legal guardian if Athlete is a minor) further agree to pay any and all medical costs, expenses and charges and to release, waive, discharge and hold harmless the Scholastic Shooting Sports Foundation, SCTP® Sponsors and the Governing Bodies, and each of their respective directors, officers, employees, agents or volunteers, from and against any liability or any claim or demand arising from or connected with such medical care and treatment.

____
Athlete - Print Name

____ ____________________
Athlete Signature Date

____
Parent/Legal Guardian - Print Name

____ ____________________
Parent/Legal Guardian Signature Date

In the event of any emergency, please contact the following individual:

Name: ________________________________ **Relationship To Athlete:** ____________________
(Please PRINT)

Address: ____

Telephone: **(Home)** ________________ **(Work)** ________________ **(Cell)** ________________

Email: ____

***** This form must be retained by Team coaches. <u>Do Not</u> send to Headquarters.**