

State Abbreviation:

Head Coach Last Name: _____



Scholastic Pistol Program 2013-14 Medical Consent Form



Team Name:		
Athlete Name:		
Address: (no PO Boxes)		
City:	State:	Zip:

In the event that the Athlete may require emergency medical care, or in the event Athlete may become ill, while participating in the Scholastic Pistol Program, Athlete (and Athlete’s parent/legal guardian if Athlete is a minor) hereby gives advanced consent to the Scholastic Shooting Sports Foundation, SPP® 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, SPP® 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 Printed Name:	
Athlete Signature:	Date:
Parent / Legal Guardian Printed Name:	
Parent / Legal Guardian Signature:	Date:

Name:		Relationship To Athlete:
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
E-mail Address:		

! This form is to be retained by the Head Coach. DO NOT send this to Headquarters!