2019-20 Medical Release Form

This **must be** completed - legibly - and signed in all areas by both the shooter and his/her parent or guardian. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. ***By signing this form the participant affirms having read and agreed to the terms and conditions listed below***

Team Name: **Dripping Springs Shooting Team**			
☐ Male ☐ Female			
First Name:	Last Name:	Birth Date:	Age:

Primary Contact: Parent or Guardian

Name:	Address:	
City, State & Zip		
Primary Phone:	Alternate Phone:	
Secondary Contact:		
Name:		
Primary Phone:	Alternate Phone:	
Primary Insurance Co:	Primary Group/Policy #:	
Family Physician Name:	Physician Phone:	
Please elaborate on any medical conditions of which we should be aware:		
Please list any medications currently being taken:		
Please list any allergies:		
If None, please write None.		
Participant Signature:	Date:	

Participant, _____

has my permission to participate in practice, competition, events, activities and travel. I approve of the leaders who will be in charge of this program. I recognize that the leaders are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed above. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team personnel to release this information in the event of a medical emergency to a third party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Parent/Guardian Signature:	Date:

Relationship to Participant:

If, during the course of my daughter's/son's activities in shooting sports, she/he should become ill or sustain an injury, I hereby **authorize** you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.

Signature:	Date:

Parent/Guardian

or

I **do not authorize** emergency medical/dental care for my daughter/son.

Signature:	Date:

Parent/Guardian

THIS FORM IS TO BE CARRIED TO ALL SANCTIONED COMPETITIONS & PRACTICES.