CYSSA CLAY TARGET PROGRAM
MEDICAL CONSENT

Team Name: _____

Athlete's Name (Please PRINT): _____

In the event that the Athlete may require emergency medical care, or in the event the Athlete may become ill, while participating in a California Youth Shooting Sports Association event, Athlete (and Athlete's parent/legal guardian if Athlete is a minor) hereby gives advanced consent to the CYSSA program, CYSSA Sponsors and involved/ affiliated organizations 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 California Youth Shooting Sports Association program, CYSSA Sponsors and involved/affiliated organizations including their respective volunteers, officers, employees, or agents, from and against any liability or any claim or demand arising from or connected with such medical care and treatment.

Athlete Signature: _____ **Date:** _____

Parent/Legal Guardian Signature: _____ **Date:** _____

IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT THE FOLLOWING INDIVIDUAL:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

E-mail: _____

⇨ **COACH PLEASE KEEP THIS FORM & BRING TO ALL CYSSA EVENTS** ⇦

Do NOT Send This Form to CYSSA Headquarters

Thank You!

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Revised 5/2016