State Abbreviation: W I

Head Coach Last Name: KRZANOWSKI

Scholastic Clay Target Program
Medical Consent Form

Team Name: Mosinee Trap Team		
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 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, Partners 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, Partners 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:**

PLEASE FILL OUT ALL FIELDS ABOVE AND BELOW - REQUIRES ATHLETES' SIGNATURE

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!