

State Abbreviation:

Head Coach's Last Name: _____

Shooting Season: _____

Enter the date range for which consent is being given,
for example: 2015-16, 2016-17, etc.



Medical Consent Form

NOTE: This form must be signed and given to the Head Coach before the Athlete can participate in any USAYESS Event!

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 the Athlete may become ill, while participating in any USAYESS (USA Youth Education in Shooting Sports) event, Athlete (and Athlete's parent/legal guardian if Athlete is a minor) hereby gives advanced consent to USAYESS (USA Youth Education Shooting Sports) 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 to release, waive, discharge and hold harmless USAYESS (USA Youth Education in Shooting Sports) and 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:
List any Athlete allergies, including drug allergies:	

Parent/Legal Guardian signature required if Athlete is a minor.

Parent/Legal Guardian Printed Name:		Relationship to Athlete:	
Parent/Legal Guardian Signature:		Date:	
Address:			
City:		State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
E-mail Address:			

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

This information is strictly confidential and can only be used by registered USAYESS Staff & Volunteers for the purpose of conducting USAYESS supported events.

www.usayess.org

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