Medical & Liability Release Form Roster

List all Participants names below.
Please include ALL completed and signed Medical & Liability release.

Team Name: _______________________________________________________

Advisor Name: ____________________________________________________

1. ___________________________________________________________________
2. ___________________________________________________________________
3. ___________________________________________________________________
4. ___________________________________________________________________
5. ___________________________________________________________________
6. ___________________________________________________________________
7. ___________________________________________________________________
8. ___________________________________________________________________
9. ___________________________________________________________________
10. ___________________________________________________________________
11. ___________________________________________________________________
12. ___________________________________________________________________
13. ___________________________________________________________________
14. ___________________________________________________________________
15. ___________________________________________________________________
16. ___________________________________________________________________
17. ___________________________________________________________________
18. ___________________________________________________________________
19. ___________________________________________________________________
20. ___________________________________________________________________
21. ___________________________________________________________________
22. ___________________________________________________________________
23. ___________________________________________________________________
24. ___________________________________________________________________
25. ___________________________________________________________________

Additional roster sheet(s) may be completed as needed.
Please DO NOT FAX or MAIL.
All FORMS will be collected at Registration.
I, the undersigned parent or legal guardian, grant permission for my daughter/son __________________ hereinafter referred to as “participant”, to participate in the SHARP International. In order, that participant may receive the necessary medical treatment in the event of an injury or illness. I hereby agree to any such medical treatment and hold SHARP International and its representatives harmless in the exercise of this authority. I acknowledge and understand that participant may sustain serious, catastrophic physical injury, illness and/or death by participating in the SHARP International. I further assume the risk of such injury, illness and/or death and agree to participation.

I agree to indemnify and hold harmless the Competition VENUE and SHARP International including but not limited to any and all; representatives, staff personnel, and administrators and/or the VENUE. For any injury, illness, and/or death sustained by participant during the course of the competition. I further release SHARP International from any medical and legal cost which may arise due to injury, illness and/or death sustained by participant.

Participant’s Signature

Parent/Guardian Signature

Team Name: ___________________________ Age: ________________

Date: _______ Home Phone: _____________ Work/Emergency Phone: ________________

Address: ______________________________________________________________________

City, State, Zip Code: ________________________________

Insurance Co.: __________________________ Policy#: __________________________

Known Medical Conditions: (Seizures, Epilepsy, Diabetes, Etc.) __________________________

Email Address: __________________________

Please list below any medication this participant is allergic to or is currently taking. If participant is on any medication, please make sure they bring their medication and take the prescribed dosage needed.

Medication(s): ___________________________________________________________________

Allergies: ______________________________________________________________________

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