
# 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.**

# Medical & Liability Release Form

***Each Participant Must Complete and Sign Form for each event.***
***All forms will be collected at time of check-in 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 herby 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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