Endicott College Athletics Department
Sport Clinic Waiver and Release Form

Name of the Program you are registering for: **GULLS SHOOTOUT**

Participant's Name (First, Middle, Last): _____

Date of Birth:_____/_____/_____ Primary Telephone Number: (_____) _____

Email Address: _____

Mailing Address: _____

Parent/Guardian Name: _____

Parent/Guardian Alternative Telephone Number: (_____) _____ Today's Date:___/___/___

Consent to Treatment/Release: In consideration of the participant's acceptance into the above-named program, as the parent/guardian of the participant, I grant permission for the staff of Endicott College to secure medical treatment through any emergency medical responder or any hospital if securing such treatment is determined to be necessary in the sole discretion of the staff of Endicott College. I understand that all possible effort will be made to inform me in case of such treatment, but I understand that the College's first priority will be to secure the necessary treatment. I do hereby agree to release Endicott College, its employees, agents, officers, staff and volunteers, from any and all liability relating to any injury sustained by my child relating to his or her participation in the program, including travel to and from the program, unless such injury is caused by the willful or gross negligence of the College or its agents.

The undersigned being a parent or legal guardian of the child requesting admittance, does hereby affirm that the participant is in good health, and suffers from no illness or disability that requires the taking of medication on a regular basis unless that condition is disclosed and approved. Furthermore, the undersigned has no knowledge of any reason the applicant cannot participant in vigorous physical activity.

I understand that, as a condition of admittance as a participant, the undersigned, on behalf of all parents and guardians, and on behalf of the participant, hereby release the sports clinic, Endicott College Athletic Department, Paul McGonagle and all other employees or agents of the clinic from any liability from any loss or damage of personal property, injury or illness, mental or physical suffered by the participant during or related to the clinic.

I hereby represent that the participant receives regular physical examinations from a qualified medical professional and I am not aware of any reason or condition that would prevent the participant's safe participation in the program and I consent to such participation. I understand that for certain designated programs I may be required to submit a medical authorization from a qualified medical professional and that the participant's eligibility for the program is conditioned up the receipt of such authorization.

List any participant allergies: _____

List any medications taken regularly by participant: _____

List any other medical conditions relevant to participation in the program: _____

_____

Insurance Information:

Insured's Name: _____ Insurance Name: _____

Insurance Policy #: _____ Insurance Phone Number: (_____) _____

Parent/Guardian Signature: _____