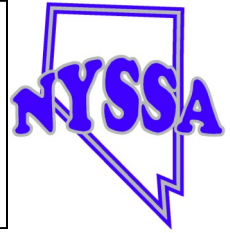




**Nevada Youth Shooting Sports  
Association**



**NYSSA Program  
Medical Consent Form**

**Team Name (required):** \_\_\_\_\_

In the event that the Athlete may require emergency medical care, or in the event Athlete may become ill, while participating in the Nevada Youth Shooting Sports (NYSSA) Program, Athlete (and Athlete's parent/legal guardian if Athlete is a minor) hereby gives advanced consent to the NYSSA 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 NYSSA, its member clubs, 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 - \_\_\_\_\_  
Print Name

Athlete \_\_\_\_\_  
Signature Date

Parent/Legal Guardian - \_\_\_\_\_  
Print Name

Parent/Legal Guardian \_\_\_\_\_  
Signature Date

**Special information you would like to make us aware of (medical/physical limitations, etc.)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child wear corrective eyewear? Yes \_\_\_ No \_\_\_ Eyeglasses \_\_\_ Contact Lenses \_\_\_

**In the event of any emergency, please contact the following individual:**

**Name:** \_\_\_\_\_ **Relationship To Athlete:** \_\_\_\_\_  
(Please PRINT)

**Address:** \_\_\_\_\_

**Telephone: (Home)** \_\_\_\_\_ **(Work)** \_\_\_\_\_ **(Cell)** \_\_\_\_\_

**Email:** \_\_\_\_\_