COFFEYVILLE RECREATION COMMISSION

YOUTH BASEBALL CLINIC

PARENT/GUARDIAN CONSENT FORM
AND
MEDICAL TREATMENT AUTHORIZATION

NAME OF CHILD_____MAILING ADDRESS_____

STREET ADDRESS_____CITY_____

HOME PHONE _____ PARENT WORK PHONE _____

DATE OF BIRTH: _____/_____/_____ AGE: _____

SCHOOL CURRENTLY ATTENDING: _____ EMAIL_____

GRADE: _____ (AS OF 2019-2020 SCHOOL YEAR)

PLEASE LIST ANY MEDICAL CONDITIONS:

_____

_____

TO WHOM IT MAY CONCERN: In the event that the above named child is taken to an emergency room or medical care facility in my absence from attendance of CRC baseball clinic at any time during the clinic, my child's coaches, or any member of the CRC staff, has my consent to authorize treatment for this child by a doctor(s) and/or medical personnel which may be deemed necessary.

I, the undersigned, do hereby acknowledge that I have given my child permission to participate in the baseball clinic with full knowledge of the risks involved and I hereby agree to assume those risks and to hold the Coffeyville Recreation Commission, City of Coffeyville, Coffeyville Community College, and all of their officers, employees, coaches, officials, volunteers and team sponsors free from liability for any injury, harm or complication of any kind.

Furthermore, I do understand that accident insurance is NOT provided by CRC, and I hereby agree to assume full responsibility for any and all expenses resulting from any accidents or injuries suffered by the above named child while participating in the baseball clinic.

I understand that a photocopy of this document shall have the same force and effect as the original.

SIGNATURE _____

RELATIONSHIP: _____ DATE: _____