



**Shoreline Community College  
2017 Dolphin Camps & Clinics  
Medical Release/Waiver Form**

Camp/Clinic Title: \_\_\_\_\_

Camp/Clinic Dates: \_\_\_\_\_

With the signature(s) below, permission is hereby granted for (participant) \_\_\_\_\_ to participate in all practice sessions, games and other activities involving Shoreline Community College (SCC) 2017 Camps/Clinics for all basketball, soccer, softball, and volleyball Camps/Clinics. This permission extends to any travel to and from campus, any and all practice sessions, games and other activities sponsored and arranged by a Shoreline Community College Camp/Clinic. This permission is granted without reservation. Recognizing the risks presented by competitive contact sports, the signature(s) below indicate(s) a knowing, voluntary release of any claim which might be asserted against Shoreline Community College, its representatives, administrative assistants, coaches, assistant coaches, managers, sponsors, chaperones, designated drivers, volunteers, and other agents representing the Shoreline Community College.

By waiving any rights to assert a claim, I am agreeing to release, absolve, indemnify and hold harmless any and all parties previously mentioned for any and all liability arising from any injuries incurred by participant in SCC Camps/Clinics.

My waiver expressly means that I, the participant's legal parent or legal guardian, accept and assume all risks and hazards inherent in and related to the activities of the Camp/Clinic, including any travel to and from any activities sponsored and arranged by the Camp/Clinic. This permission also includes my authorization for emergency medical treatment deemed appropriate and necessary by any coach, assistant coach or representative or agent thereof for participant, including transportation to the nearest medical facility adequate to treat the emergency.

Participant \_\_\_\_\_ has the following medical condition(s): \_\_\_\_\_

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

**PLEASE PRINT**

Mother's name \_\_\_\_\_ Home Phone \_\_\_\_ - \_\_\_\_\_ Work/Cell Phone \_\_\_\_ - \_\_\_\_\_

Father's name \_\_\_\_\_ Home Phone \_\_\_\_ - \_\_\_\_\_ Work/Cell Phone \_\_\_\_ - \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_

Preferred Hospital \_\_\_\_\_ Address \_\_\_\_\_

Health Insurance Plan \_\_\_\_\_ Medical Plan # \_\_\_\_\_

I have read the authorization to play, medical release and waiver, and acknowledge that I understand it and agree to be bound by it.

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

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